Journal of the Senate

Number 16 **Friday, April 19, 1991**

CALL TO ORDER

The Senate was called to order by the President at 1:00 p.m. A quorum present—31:

Madam President	Dantzler	Kiser	Thomas
Beard	Diaz-Balart	Langley	Thurman
Brown	Dudley	Malchon	Walker
Bruner	Forman	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Wexler
Crenshaw	Jenne	Scott	Yancey
Crotty	Johnson	Souto	

Excused: Senators Davis, Gordon and Jennings; Senator Weinstein at 2:35 p.m.

PRAYER

The following prayer was offered by James C. Vaughn, Jr., Senate Reading Clerk:

The God of Abraham, Isaac and Jacob, we humbly pause prior to tackling the business before us today, where we ask that you waive the rules of your divine judgment, and we offer a motion that you will cleanse the thoughts and hearts of these noble men and women by the inspiration of your holy spirit. Give them strong minds, great hearts, true faith, and a ready determination.

O Holy One of Israel, because we live in a time that demands servants who are more altruistic and less opportunistic, we offer a substitute motion that you will continue to give Florida men and women whom the lust of office cannot kill; men and women whom the spoils of office cannot buy; men and women who possess opinions and a will; men and women who can stand before a demagogue and condemn treacherous flatteries without winking. Continue to give Florida servants like these men and women who serve in the Florida Senate. We thank you for their sun-crowned motives, their tall character, and their lives that live above the fog in their public duty and in their private thinking.

Then, Lord, when the 1991 Legislative Session has become inscribed in the annals of history for future generations, perhaps the words of Paul Lawrence Dunbar will express the mood of the moment: "A crust of bread and a corner to sleep in, a minute to smile and an hour to weep in, a pint of joy to a peck of trouble, and never a laugh but the moans come double, and that is life." Amen.

CONSIDERATION OF RESOLUTION

On motion by Senator Thomas, the rules were waived by unanimous consent and the following resolution was introduced out of order:

By Senator Thomas—

SR 2482—A resolution commending Charlie M. Macon for a distinguished career in state government.

WHEREAS, Charlie M. Macon was born in Perry, Florida, on May 25, 1925, and

WHEREAS, Charlie Macon has been a loyal employee of the Department of Labor and Employment Security for over thirty-three years, having begun his career as an examiner with the Division of Workers' Compensation and risen through the ranks to become Director of the Division of Workers' Compensation, and

WHEREAS, Charlie Macon has been involved in civic, educational, and religious activities in his hometown of Greensboro, and throughout Gadsden County and Leon County where he has served as past president of his local Kiwanis Club, a trustee and deacon of his church as well as a Sunday School teacher, and as a board member and former chairman of the Tallahassee Community College Board of Trustees, and

WHEREAS, Charlie Macon throughout his career has been involved in the professional activities associated with his chosen vocation, having served as President of the Southern Association of Workers' Compensation Administrators and Chairman of the Administrations Procedures and Statistics Committee, and

WHEREAS, Charlie M. Macon will retire from the Department of Labor and Employment Security this month, and

WHEREAS, Charlie M. Macon exemplifies the best qualities of a government employee and is an exemplary citizen, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Florida Senate congratulates Charlie M. Macon on his outstanding career and accomplishments with the Department of Labor and Employment Security and wishes him a happy and prosperous retirement.

BE IT FURTHER RESOLVED that a copy of this resolution, with the Seal of the Senate affixed, be presented to Charlie M. Macon as a tangible token of the sentiments of the Florida Senate.

On motion by Senator Thomas, **SR 2482** was read by title and was read the second time in full and adopted.

SPECIAL ORDER

On motions by Senator Kurth, by two-thirds vote **SB 606** was removed from the special order calendar and withdrawn from further consideration.

CS for SB 1548—A bill to be entitled An act relating to public records; amending s. 119.07, F.S.; exempting records pertaining to state-certified firefighters and their families from disclosure as public records; exempting records pertaining to judges and justices of the state courts system and their families from disclosure as public records; providing an effective date.

—was read the second time by title. On motion by Senator Dantzler, by two-thirds vote **CS for SB 1548** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—31 Nays—None

CS for SB 1342—A bill to be entitled An act relating to parimutuels; amending s. 550.012, F.S.; authorizing the Pari-mutuel Commission to grant additional days to certain permitholders; changing dates for issuance of requests for additional days; amending s. 550.03, F.S.; requiring permitholders to distribute as proceeds on charity days an amount equal to the state tax that would have been paid; amending s. 550.09, F.S.; imposing an additional tax on handle on the surcharge on certain winning tickets authorized pursuant to s. 550.633; amending s. 550.262, F.S.; requiring the permitholders conducting a thoroughbred race to pay a specific sum, as breeders' and stallion awards, on all pari-mutuel pools conducted during the race, including all intertrack races and Breeder's Cup races conducted outside the state; amending s. 550.263, F.S.; providing that uncashed tickets and breakage tax on live racing conducted by thoroughbred permitholders shall be retained by such permitholder; amending s. 550.2635, F.S.; exempting certain permitholders from the purse requirements of s. 550.62, F.S.; amending s. 550.356, F.S.; authorizing certain horse tracks that have made an election authorized for capital improvements to retain additional commission; amending s. 550.52, F.S.; providing for notification that a permitholder does not intend to operate any racing days; providing for a payment to cover part of the loss to the state; amending s. 550.61, F.S.; prohibiting a permitholder that elects to broadcast its signal from entering into an exclusive agreement with a permitholder eligible to conduct intertrack wagering; authorizing additional racing days to certain quarter horse permitholders; providing that provi-

sions relating to the suspension or revocation of a quarter horse permit are inapplicable under certain conditions; placing restrictions on intertrack wagering; amending s. 550.62, F.S.; changing percentages that horseracing host tracts must pay as purses to certain permitholders; amending s. 550.63, F.S.; changing the percentage that guest tracks are paid on intertrack wagering; creating s. 550.633, F.S.; providing for a surcharge on certain winning tickets; creating s. 550.635, F.S.; providing for an additional percentage that may be paid by a harness track race permitholder to any guest track that receives broadcasts and accepts wagers on races from the host track; amending s. 550.64, F.S.; providing applicability of related laws; creating s. 551.1535, F.S., establishing the Jai Alai Tournament of Champions Meet; providing for the repeal of ss. 550.2635(2), (3), (4), (9), 550.2636(2), (3), (4), (9), 550.1635(2), (3), (4), (6), 551.1535(3), (4), (5), (7), F.S.; providing an effective date.

—was read the second time by title.

Senator Thurman moved **Amendment 1**.

Senator Thurman moved **Amendment 1A** which was adopted.

Senator Thurman moved **Amendment 1B**.

Senator Thurman moved **Substitute Amendment 1C** which was adopted.

Senator Thurman moved **Amendment 1D** which was adopted.

Amendment 1 as amended was adopted.

Senator Thurman moved **Amendment 2**.

Senators Childers and Thurman offered **Amendment 2A** which was moved by Senator Thurman and adopted.

Amendment 2 as amended was adopted.

On motion by Senator Jenne, by two-thirds vote **CS for SB 1342** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—31 Nays—1

On motion by Senator Thurman, the rules were waived and **CS for SB 1342** was ordered immediately certified to the House.

SB 1682—A bill to be entitled An act relating to public officers and employees; amending s. 112.3188, F.S.; providing for confidentiality of certain information given to internal auditors and inspectors general; providing an effective date.

—was read the second time by title. On motion by Senator Thurman, by two-thirds vote **SB 1682** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—31 Nays—None

CS for SB 296—A bill to be entitled An act relating to child support; amending s. 61.13, F.S.; providing for child support for children who are over age 18 and who have not yet graduated from high school; amending s. 61.30, F.S.; amending the deductions from gross income allowable in computing the parents' combined net income so as to determine the minimum child support need; requiring the court order for child support to state the actual dollar amount provided as calculated under these guidelines; amending s. 742.031, F.S.; revising language with respect to court-ordered support in hearings concerning determination of paternity; amending s. 743.07, F.S.; providing that a court may require support for a person over the age of 18 years if the person is in high school; providing an effective date.

—was read the second time by title.

Senator Dudley moved **Amendments 1** and **2** which were adopted.

On motion by Senator Forman, by two-thirds vote **CS for SB 296** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—31 Nays—1

On motion by Senator Forman, the rules were waived and **CS for SB 296** was ordered immediately certified to the House.

CS for SB 596—A bill to be entitled An act relating to lobbying; amending s. 11.062, F.S.; prohibiting departments of the executive branch, universities, community colleges, and water management districts from using public funds to retain lobbyists; providing that full-time employees of these entities are exempt; prohibiting lobbyists from accepting compensation derived from public funds; providing penalties; authorizing complaints to be filed with the Ethics Commission; authorizing the commission to adopt rules; providing an effective date.

—was read the second time by title.

Senator Thomas moved **Amendment 1** which was adopted.

On motion by Senator McKay, by two-thirds vote **CS for SB 596** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—30 Nays—None

On motion by Senator McKay, the rules were waived and **CS for SB 596** was ordered immediately certified to the House.

CS for SB 1536—A bill to be entitled An act relating to veterinary medical practice; amending s. 474.202, F.S.; revising and providing definitions; amending s. 474.203, F.S.; modifying certain exemptions; amending s. 474.2065, F.S.; modifying provisions relating to fees; amending s. 474.211, F.S.; revising continuing education requirements for renewal of license, to include filing of an affidavit of compliance; providing for automatic reversion to involuntary inactive status upon nonrenewal, including notice thereof; amending s. 474.212, F.S.; revising provisions relating to inactive status, to provide for voluntary and involuntary status; providing for renewal, reactivation, and relicensure; providing for fees; providing rulemaking authority; requiring specified notice prior to a license becoming void; amending s. 474.213, F.S.; expanding prohibitions; providing penalties; amending s. 474.214, F.S.; expanding grounds for disciplinary action; expanding applicable penalties; amending s. 474.215, F.S.; revising provisions relating to premises permits and fees therefor; providing for temporary permits; providing exemptions; amending s. 474.216, F.S., to conform; amending s. 474.217, F.S.; revising requirements for licensure by endorsement; amending s. 455.241, F.S.; conforming cross-references; providing an effective date.

—was read the second time by title. On motion by Senator Crotty, by two-thirds vote **CS for SB 1536** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—31 Nays—None

On motion by Senator Crotty, the rules were waived and **CS for SB 1536** was ordered immediately certified to the House.

CS for SB 1026—A bill to be entitled An act relating to motorcycle safety; amending s. 316.211, F.S., relating to equipment; providing exceptions; providing an effective date.

—was read the second time by title.

Senator Langley moved **Amendments 1** and **2** which were adopted.

On motion by Senator Gardner, by two-thirds vote **CS for SB 1026** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—22 Nays—10

CLAIM BILLS

On motions by Senator Forman, by two-thirds vote—

CS for HB 339—A bill to be entitled An act for the relief of Terry Lee Russell and Rhonda Russell, as parents of Terry Lee Russell, Jr., deceased; providing an appropriation to compensate them for the wrongful death of their son, who died as a result of the negligence of the Department of Natural Resources and the negligence of a lifeguard service that contracted with the state; providing an effective date.

—a companion measure, was substituted for **SB 302** and by two-thirds vote read the second time by title. On motion by Senator Forman, by two-thirds vote **CS for HB 339** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—32 Nays—1

On motions by Senator Forman, by two-thirds vote—

CS for HB 269—A bill to be entitled An act for the relief of Brenda Smith and Steve Smith; providing an appropriation to compensate them for the damages sustained as a result of injury to Brenda Smith and for the wrongful death of their daughter, Leslie Smith; providing an effective date.

—a companion measure, was substituted for **SB 482** and by two-thirds vote read the second time by title. On motion by Senator Forman, by two-thirds vote **CS for HB 269** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—29 Nays—None

SB 2454—A bill to be entitled An act relating to the City of Miami, Dade County; providing for the relief of Damian Garcia to compensate him for damages for injuries received in an accident at a beach owned and maintained by the city through the negligence of the city; providing for payment of said compensation; providing an effective date.

—was read the second time by title.

The Committee on Finance, Taxation and Claims recommended **Amendments 1, 2** and **3** which were moved by Senator Diaz-Balart and adopted.

On motion by Senator Diaz-Balart, by two-thirds vote **SB 2454** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—28 Nays—None

On motion by Senator Diaz-Balart, the rules were waived and **SB 2454** was ordered immediately certified to the House.

On motions by Senator Diaz-Balart, by two-thirds vote **HB 1419** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Diaz-Balart—

HB 1419—A bill to be entitled An act relating to the School District of Dade County, Florida; providing for the relief of Alberto Sosa, a minor, by and through his parents and next friends, Magaly and Alberto Sosa, Sr., and Magaly and Alberto Sosa, Sr., individually; directing the district school board to compensate them for serious physical injury suffered by Alberto Sosa while a student at Rockway Junior High School; providing an effective date.

—a companion measure, was substituted for **SB 604** and read the second time by title. On motion by Senator Diaz-Balart, by two-thirds vote **HB 1419** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—32 Nays—1

On motions by Senator Diaz-Balart, by two-thirds vote **HB 189** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Diaz-Balart—

HB 189—A bill to be entitled An act relating to the relief of Yolanda Amara Torres, individually, and as mother and natural guardian of Oscar Rosa, a minor, for injuries sustained by Oscar Rosa through the negligence of Metropolitan Dade County; providing an effective date.

—a companion measure, was substituted for **SB 770** and read the second time by title. On motion by Senator Diaz-Balart, by two-thirds vote **HB 189** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—30 Nays—None

On motions by Senator Kurth, by two-thirds vote—

CS for HB 287—A bill to be entitled An act for the relief of Jack Forte; providing an appropriation to compensate him for the wrongful taking of his property by the State of Florida; providing an effective date.

—a companion measure, was substituted for **SB 1126** and by two-thirds vote read the second time by title. On motion by Senator Kurth, by two-thirds vote **CS for HB 287** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—31 Nays—None

SB 1168—A bill to be entitled An act relating to the City of Clearwater; providing for the relief of Marsha Ann Yukon Frazier, surviving wife of Randy Yukon; Shelby Yukon, surviving child of Randy Yukon, and Joy Frisby, surviving wife of Nathan Frisby; directing the city commission of the City of Clearwater to pay the balance of a settlement agreement in favor of Marsha Ann Yukon Frazier and Joy Frisby; providing an effective date.

—was read the second time by title. On motion by Senator Kiser, by two-thirds vote **SB 1168** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—26 Nays—None

On motions by Senator Forman, by two-thirds vote **HB 885** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Forman—

HB 885—A bill to be entitled An act relating to Broward County; providing for the relief of Diana Martinez mother of Christina Martinez, a minor; authorizing and directing the South Broward Hospital District to compensate her for injuries suffered by Christina Martinez as a result of the negligence of the South Broward Hospital District doing business as Memorial Hospital; providing an effective date.

—a companion measure, was substituted for **SB 1270** and read the second time by title. On motion by Senator Forman, by two-thirds vote **HB 885** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—30 Nays—None

On motions by Senator Diaz-Balart, by two-thirds vote **HB 1963** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Diaz-Balart—

HB 1963—A bill to be entitled An act relating to Metropolitan Dade County; providing for the relief of Michelle Ruiz; directing Metropolitan Dade County to compensate Michelle Ruiz, individually, for catastrophic personal injuries and for the death of her mother, Milan Yi Ruiz, in an automobile accident resulting from negligence on the part of the county; providing an effective date.

—a companion measure, was substituted for **SB 1518** and read the second time by title. On motion by Senator Diaz-Balart, by two-thirds vote **HB 1963** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—29 Nays—None

On motions by Senator Grant, by two-thirds vote **CS for HB 367** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Grant—

CS for HB 367—A bill to be entitled An act relating to Hillsborough County; providing for the relief of Alfreeda K. Mobley; authorizing and directing Hillsborough County to compensate her for severe personal injuries sustained as a result of the negligence of Hillsborough County; providing an effective date.

—a companion measure, was substituted for **SB 1824** and read the second time by title. On motion by Senator Grant, by two-thirds vote **CS for HB 367** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—18 Nays—11

On motions by Senator Bankhead, by two-thirds vote **CS for HB 981** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Bankhead—

CS for HB 981—A bill to be entitled An act relating to the City of Neptune Beach, Duval County; providing for the relief of Richard Goree, to compensate him for injuries suffered as a result of being struck by a city police car; providing for payment by the city to Barbara Hayden, mother and guardian of Richard Goree; providing an effective date.

—a companion measure, was substituted for **SB 1938** and read the second time by title. On motion by Senator Bankhead, by two-thirds vote **CS for HB 981** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—32 Nays—1

On motions by Senator Dudley, by two-thirds vote **HB 369** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Dudley—

HB 369—A bill to be entitled An act relating to Lee County; providing for the relief of Suzanne Alexander; providing for attorney's fees; compensating her for personal injuries sustained as a result of an automobile accident occurring on May 1, 1985, in Fort Myers, Florida; providing for payment by Lee County; providing an effective date.

—a companion measure, was substituted for **SB 2368** and read the second time by title. On motion by Senator Dudley, by two-thirds vote **HB 369** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—31 Nays—None

On motions by Senator Bankhead, by two-thirds vote **CS for HB 979** was withdrawn from the Special Master; and the Committee on Finance, Taxation and Claims.

On motion by Senator Bankhead—

CS for HB 979—A bill to be entitled An act relating to the City of Jacksonville, Duval County; providing for the relief of Donald D. Moulden, to compensate him for injuries sustained as a result of the negligent maintenance of a traffic control device by the city; providing for payment by the city; providing an effective date.

—a companion measure, was substituted for **SB 2380** and read the second time by title. On motion by Senator Bankhead, by two-thirds vote **CS for HB 979** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas— 30 Nays—None

SB 2388—A bill to be entitled An act relating to Metropolitan Dade County; providing for the relief of Annette and Timothy Holmes; directing Metropolitan Dade County to compensate them for personal injuries sustained by Annette Holmes as a result of a Metrobus accident; providing an effective date.

—was read the second time by title. On motion by Senator Casas, by two-thirds vote **SB 2388** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—29 Nays—None

SPECIAL ORDER, continued

CS for SB 60—A bill to be entitled An act relating to private transportation facilities; creating s. 334.30, F.S.; authorizing the Department of Transportation, with legislative approval, to enter into agreements allowing private entities to construct and operate privately owned and financed transportation facilities; authorizing the private entity to charge tolls or fares; requiring private transportation facilities to comply with all requirements of federal, state, and local laws, state, regional, and local comprehensive plans, department rules, policies, procedures, and standards for transportation facilities, and any other conditions which the department determines to be in the public's best interest; authorizing the department to exercise any power possessed by it in relation to such facilities; providing an effective date.

—was read the second time by title.

The Committee on Finance, Taxation and Claims recommended **Amendment 1** which was moved by Senator Beard and adopted.

On motion by Senator Beard, by two-thirds vote **CS for SB 60** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—30 Nays—1

SB 552—A bill to be entitled An act relating to local government officials; amending s. 115.09, F.S.; providing for a temporary vacancy created in the membership of the governing body of a local government due to the military service of a member to be filled by vote of the body's remaining members; providing an effective date.

—was read the second time by title.

Two amendments were adopted to **SB 552** to conform the bill to **CS for HB 983**.

Pending further consideration of **SB 552** as amended, on motions by Senator Crotty, by two-thirds vote **CS for HB 983** was withdrawn from the Committees on Community Affairs; and Executive Business, Ethics and Elections.

On motion by Senator Crotty—

CS for HB 983—A bill to be entitled An act relating to military leave; amending s. 115.11, F.S.; providing that where a military leave of absence for any elected municipal officer exceeds a certain time period, a temporarily unoccupied position exists in that office; providing for the filling of the temporarily unoccupied position; providing for the termination of the temporary appointment; providing an effective date.

—a companion measure, was substituted for **SB 552** and read the second time by title. On motion by Senator Crotty, by two-thirds vote **CS for HB 983** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—33 Nays—None

CS for CS for SB 1264—A bill to be entitled An act relating to saltwater fisheries; creating s. 370.1535, F.S.; providing for the regulation of dead shrimp harvesting in Tampa Bay; requiring a permit from the Department of Natural Resources for dead shrimp production; specifying criteria for a permit; requiring a permit fee; specifying the deposit of fees; limiting the number of permits; prohibiting transfer of permits; requiring production of permits; requiring compliance with certain rules of the Marine Fisheries Commission; providing a definition; providing an effective date.

—was read the second time by title. On motion by Senator Beard, by two-thirds vote **CS for CS for SB 1264** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—31 Nays—None

CS for SB 1440—A bill to be entitled An act relating to state lands; amending s. 253.03, F.S.; authorizing the Board of Trustees of the Internal Improvement Trust Fund to adopt rules governing the use of sovereignty submerged lands; amending s. 253.04, F.S.; including vessels within a group of structures which the Board of Trustees of the Internal Improvement Trust Fund may order removed or altered under certain circumstances; providing an effective date.

—was read the second time by title.

Senators Kirkpatrick and Brown offered **Amendments 1** and **2** which were moved by Senator Brown and adopted.

On motion by Senator Brown, by two-thirds vote **CS for SB 1440** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—32 Nays—1

Consideration of **SB 2228** and **CS for CS for SB 2084** was deferred.

SB 1838—A bill to be entitled An act relating to adult congregate living facilities; amending s. 400.411, F.S.; requiring each applicant for a license to operate a facility to file with the Department of Health and Rehabilitative Services information relating to certain officers and shareholders of the facility and information relating to the financial stability of the applicant; amending s. 400.417, F.S.; specifying conditions under which an applicant for renewal of a license must file proof of financial ability to operate; requiring each facility to report any adverse court action relating to the financial viability of the facility to the Department of Health and Rehabilitative Services; amending s. 400.431, F.S.; providing for an administrative fine for terminating operation of a facility with-

out providing the required notice; providing for disposition and use of proceeds from such fines; providing an effective date.

—was read the second time by title.

The Committee on Health and Rehabilitative Services recommended **Amendment 1** which was moved by Senator Weinstock and adopted.

Senator Weinstock moved **Amendments 2** and **3** which were adopted.

On motion by Senator Weinstock, by two-thirds vote **SB 1838** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—31 Nays—None

SB 1654—A bill to be entitled An act relating to developmental disabilities; amending s. 393.063, F.S.; defining the term "supported living"; amending s. 393.066, F.S.; including supported living among the range of community services and treatments for persons who are developmentally disabled; amending s. 393.068, F.S.; clarifying that certain payment methods and rate schedules do not apply to the provision of in-home subsides through the family care program; creating s. 393.069, F.S.; requiring the Department of Health and Rehabilitative Services to develop a plan for paying in-home subsidies; providing guidelines for the uses of in-home subsidies; providing requirements for the subsidies; providing an effective date.

—was read the second time by title. On motion by Senator Forman, by two-thirds vote **SB 1654** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—27 Nays—None

On motion by Senator Forman, the rules were waived and **SB 1654** was ordered immediately certified to the House.

CS for SB 1662—A bill to be entitled An act relating to children; amending s. 39.01, F.S.; providing definitions; amending s. 39.41, F.S.; providing additional disposition options to the court in dependency proceedings; amending s. 39.453, F.S.; providing deadlines for certain judicial reviews; amending s. 409.165, F.S.; providing legislative intent for the expenditure of certain funds; providing for certain funds to be used to meet the needs of dependent children; providing an effective date.

—was read the second time by title.

Senator Bankhead moved **Amendment 1**.

Further consideration of **CS for SB 1662** with pending **Amendment 1** was deferred.

CS for SB 1116—A bill to be entitled An act relating to the transportation of hazardous materials; creating a study commission to make recommendations to the Legislature with respect to the intrastate transportation of hazardous materials by motor carrier, rail, air, and water; providing for the membership and powers and duties of the commission; providing for a report; providing for the dissolution of the commission; providing an effective date.

—was read the second time by title.

Senator Weinstock moved **Amendment 1** which was adopted.

On motion by Senator Weinstock, by two-thirds vote **CS for SB 1116** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—33 Nays—None

On motions by Senator Meek, by two-thirds vote **HB 1221** was withdrawn from the Committees on Judiciary; Health and Rehabilitative Services; and Appropriations.

On motion by Senator Meek—

HB 1221—A bill to be entitled An act relating to adoption; amending s. 63.022, F.S.; providing legislative intent to maintain sibling groups, whenever possible; amending s. 63.082, F.S.; revising requirements with respect to execution of consent; amending s. 63.165, F.S.; providing duty to inform adoptive parents of the state registry of adoption information; amending s. 63.185, F.S.; providing an exception to residence requirements for stepparent adoptions; amending s. 409.166, F.S.; authorizing the Department of Health and Rehabilitative Services to reimburse certain adoptive parents for nonrecurring adoption expenses; providing an effective date.

—a companion measure, was substituted for **SB 2228** and read the second time by title.

Senator Langley moved **Amendments 1** and **2** which were adopted.

On motion by Senator Meek, by two-thirds vote **HB 1221** as amended was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—30 Nays—None

CS for SB 938—A bill to be entitled An act relating to criminal sentencing; amending s. 921.001, F.S.; revising the membership of the Sentencing Commission and adding the Secretary of the Department of Corrections or his designee as a member; mandating a revision of the sentencing guidelines by the commission; deleting provisions which authorize a court to impose a sentence outside the guidelines under certain circumstances; reenacting s. 947.168(1), F.S., relating to persons serving parole-eligible and parole-ineligible sentences, to incorporate a cross-reference; providing for the revised sentencing guidelines to address certain sections in the law; providing an effective date.

—was read the second time by title.

The Committee on Criminal Justice recommended **Amendments 1** and **2** which were moved by Senator Casas and adopted.

Senator Casas moved **Amendments 3** and **4** which were adopted.

On motion by Senator Casas, by two-thirds vote **CS for SB 938** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—32 Nays—None

On motion by Senator Casas, the rules were waived and **CS for SB 938** was ordered immediately certified to the House.

CS for CS for SB 1680—A bill to be entitled An act relating to education; amending s. 229.551, F.S.; requiring the Department of Education to collect, analyze, and disseminate certain vocational education reports as a public service; providing definitions; requiring the department, rather than school districts, to determine rates for certain outcomes of job-preparatory vocational education programs; removing a funding penalty; directing the department, each school district, and the State Board of Independent Postsecondary Vocational, Technical, Trade, and Business Schools to disseminate certain outcome information on certain vocational education programs; amending s. 246.207, F.S.; authorizing independent postsecondary vocational, technical, trade, and business schools to participate in the department's reporting of outcomes of vocational education programs; requiring information reported to be comparable; requiring a joint cooperative strategic plan to meet the current and future economic development and workforce needs of the state; providing effective dates.

—was read the second time by title. On motion by Senator Walker, by two-thirds vote **CS for CS for SB 1680** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—30 Nays—None

CS for CS for SB 498—A bill to be entitled An act relating to suspension of driving privileges; amending ss. 322.2615, 322.271, 322.282, 322.64, F.S.; revising provisions relating to administrative suspension of the driving privilege and disqualification from operating a commercial motor vehicle for driving under the influence or refusing to submit to a requested breath, blood, or urine test; providing that law enforcement officers or correctional officers may take such actions; specifying information that may be considered in a review of such action; specifying circumstances under which a review must be conducted; specifying scope of review; providing circumstances for issuance of temporary permits and licenses for business or employment use; specifying venue for appeals of suspensions and disqualifications; providing for reinstatement of the driving privilege under certain circumstances; deleting provision requiring continuous 1-year participation in a DUI program as a condition for reinstatement of a permanently revoked driving privilege; providing for severability; providing an effective date.

—was read the second time by title. On motion by Senator Langley, by two-thirds vote **CS for CS for SB 498** was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—29 Nays—None

REPORTS OF COMMITTEES

The Committee on Rules and Calendar submits the following bills to be placed on the Special Order Calendar for Friday, April 19, 1991: SB 606, CS for SB 1548, CS for SB 1342, SB 1682, CS for SB 296, CS for SB 596, CS for SB 1536, CS for SB 1026, SB 302, SB 482, SB 2454, SB 604, SB 770, SB 1126, SB 1168, SB 1270, SB 1518, SB 1824, SB 1938, SB 2368, SB 2380, SB 2388, CS for SB 60, SB 552, CS for CS for SB 1264, CS for SB 1440, SB 2228, CS for CS for SB 2084, SB 1838, SB 1654, CS for SB 1662, CS for SB 1116, CS for SB 938, CS for CS for SB 1680, CS for CS for SB 498

Respectfully submitted,
Pat Thomas, Chairman

The Committee on Finance, Taxation and Claims recommends a committee substitute for the following: CS for SB 1890

The bill with committee substitute attached was referred to the Committee on Appropriations under the original reference.

The Committee on Finance, Taxation and Claims recommends a committee substitute for the following: SB 1720

The bill with committee substitute attached was placed on the calendar.

FIRST READING OF COMMITTEE SUBSTITUTES

By the Committee on Finance, Taxation and Claims; and Senator Bankhead—

CS for SB 1720—A bill to be entitled An act relating to local option tourist development taxes; amending s. 125.0104, F.S.; authorizing the use of such taxes to finance certain costs relating to beach or shoreline structures; providing an effective date.

By the Committees on Finance, Taxation and Claims; and Commerce—

CS for CS for SB 1890—A bill to be entitled An act relating to mortgage brokerage and lending; providing general provisions; providing definitions; providing for powers and duties of the Department of Banking and Finance; providing for investigations, complaints, and examinations; providing for injunctions to restrain violations; providing for cease and desist orders and refund orders; providing for evidence, examiner's worksheets, investigative reports, and other related documents; providing for books, accounts, and records; providing for examinations by the department; providing for the Mortgage Brokerage Guaranty Fund; providing penalties; providing for liability in the case of unlawful transactions; providing for statutory or common-law remedies; providing for public records; providing for the applicability of the act; providing for conflicting interest; prohibiting waivers; prohibiting a mortgage broker from practicing without a current, active license; providing provisions with respect to mortgage brokers; providing exemptions; providing for licensure as a mortgage brokerage business; providing for renewal of a business license and for renewal of a permit; providing for licensure and renewal as a mortgage broker; providing principal and branch broker requirements; providing for branch offices; providing for books, accounts, and records; providing for disclosures; providing principal place of business requirements; providing licensee requirements; providing for administrative penalties and fines and for license violations; providing for brokerage fees; providing requirements for brokering loans to noninstitutional investors; providing exemptions; providing requirements with respect to mortgage lenders; providing for lender's license requirements; providing for correspondent mortgage lender's license requirements; providing for audited financial statements; providing for mortgage lender's licenses and branch office licenses and renewals; providing a saving clause; providing a loan application process; providing for lock-in agreements; providing a commitment process; providing for the expiration of lock-in agreements and commitments; providing for administrative penalties and fines and license violations; providing for mortgage lender or correspondent mortgage lender acting as a broker; prescribing prohibited practices; providing for fees and charges that are not considered interest or finance charges; providing requirements for selling loans to noninstitutional investors; providing for servicing audits; providing for offering of other products and services; providing for expiration of the foregoing provisions and for review in advance thereof; repealing chapter 494, F.S., the Mortgage Brokerage Act; repealing chapter 90-353, Laws of Florida, appearing as chapter 521, F.S., 1990 Supplement, the Mortgage Lending Act; amending s. 201.23, F.S., relating to the exemption of foreign notes and other written obligations from excise taxes, s. 215.321, F.S., relating to the Regulatory Trust Fund, s. 420.507, F.S., relating to the powers of the Florida Housing Finance Agency, s. 520.52, F.S., relating to installment sales finance licensees, s. 520.63, F.S., relating to home improvement finance sellers, s. 607.0505, F.S., relating to registered agents, s. 626.988, F.S., relating to employment insurance solicitors and agents, and s. 687.12, F.S., relating to parity of interest rates among lenders or creditors; revising cross-references in said sections to conform to this act; providing an effective date.

MOTIONS RELATING TO COMMITTEE REFERENCE

On motions by Senator Gardner, by two-thirds vote **Senate Bills 482, 206, CS for SB 268, SB 384, SB 1708, CS for CS for SB 2136, CS for SB 2182** and **CS for SB 350** were withdrawn from the Committee on Appropriations.

On motions by Senator Gardner, by two-thirds vote **CS for SB 1890** and **HB 2069** were withdrawn from the Committee on Appropriations.

On motion by Senator Thomas, by two-thirds vote **CS for SB 848** was withdrawn from the Committee on Rules and Calendar.

MOTIONS

On motion by Senator Dudley, the House was requested to return **CS for SB 1694**.

On motions by Senator Thomas, the rules were waived and the Special Order Subcommittee of the Committee on Rules and Calendar was granted permission to meet upon adjournment this day and at 1:00 p.m. Monday, April 22.

MESSAGES FROM THE HOUSE OF REPRESENTATIVES

First Reading

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has passed CS for HB 269, CS for HB 287, CS for HB 339 and requests the concurrence of the Senate.

John B. Phelps, Clerk

By the Committee on Claims and Representatives Press and Hill—

CS for HB 269—A bill to be entitled An act for the relief of Brenda Smith and Steve Smith; providing an appropriation to compensate them for the damages sustained as a result of injury to Brenda Smith and for the wrongful death of their daughter, Leslie Smith; providing an effective date.

(Substituted for **SB 482** on the special order calendar this day.)

By the Committee on Claims and Representative Sansom and others—

CS for HB 287—A bill to be entitled An act for the relief of Jack Forte; providing an appropriation to compensate him for the wrongful taking of his property by the State of Florida; providing an effective date.

(Substituted for **SB 1126** on the special order calendar this day.)

By the Committee on Claims and Representative Silver—

CS for HB 339—A bill to be entitled An act for the relief of Terry Lee Russell and Rhonda Russell, as parents of Terry Lee Russell, Jr., deceased; providing an appropriation to compensate them for the wrongful death of their son, who died as a result of the negligence of the Department of Natural Resources and the negligence of a lifeguard service that contracted with the state; providing an effective date.

(Substituted for **SB 302** on the special order calendar this day.)

RETURNING MESSAGES ON SENATE BILLS

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has passed with amendments CS for SB 632 and requests the concurrence of the Senate, or failing to concur, requests the Senate to appoint a committee of conference to meet with a like committee appointed from the House to resolve the differences between the houses.

House Conferees: Abrams, Graber, C. Fred Jones, Bloom, Dennis Jones, Bainter, Grindle, Gordon, Lippman

John B. Phelps, Clerk

CS for SB 632—A bill to be entitled An act relating to health care service programs; amending ss. 641.201, 641.21, F.S.; deleting obsolete language to conform to changes made by the act; providing additional requirements for persons applying for a certificate of authority from the Department of Insurance to operate a health maintenance organization; requiring the Department of Health and Rehabilitative Services to adopt rules governing the operation of certain organizations providing prepaid health care and social services; amending s. 641.22, F.S.; providing additional requirements for obtaining a certificate of authority to operate a health maintenance organization; amending s. 641.221, F.S.; providing requirements for expanding the service area of a health maintenance organization; amending s. 641.23, F.S.; providing additional circumstances under which the department may revoke an organization's certificate of authority; providing a penalty; creating s. 641.275, F.S.; requiring periodic examinations of the quality of health care services provided by health maintenance organizations; exempting certain medical records and examination reports from public records law; providing for future legislative review of these exemptions pursuant to the Open Government Sunset Review Act; providing for subpoenas and enforcement thereof; providing a penalty; providing for the examination of health maintenance organizations that operate under certificates issued by the Department of Health and Rehabilitative Services prior to a specified date; amending s. 641.28, F.S.; deleting obsolete provisions; amending s. 641.29, F.S.; requiring health maintenance organizations to pay an annual assessment; providing for deposit of assessment proceeds into the Health Care Services Trust Fund; creating s. 641.295, F.S.; establishing the Health Care Services Trust Fund; providing for the transfer of certain funds in the Health Maintenance Organization Quality Care Trust Fund into the Health Care Services Trust Fund on a specified date; amending s. 641.30, F.S.; providing circumstances under which certain health maintenance organizations are exempt from specified hospital licensing requirements; transferring, renumbering, and amending s. 641.51, F.S.; prohibiting modification of the professional judgment of certain health care providers under certain circumstances; transferring, renumbering, and amending s. 641.55, F.S.; requiring the Department of Insurance to administer the internal risk management programs of health maintenance organizations; continuing the exemption of certain reports and records from public records law; providing for future review of these exemptions pursuant to the Open Government Sunset Review Act; transferring, renumbering, and amending s. 641.54, F.S., relating to hospital and physician information disclosure; amending s. 641.31, F.S.; requiring health maintenance organizations to provide additional notification regarding subscriber's rights and the organization's grievance process; creating s. 641.31085, F.S.; providing requirements for a subscriber grievance procedure; requiring the department to investigate unresolved grievances; amending s. 641.311, F.S.; authorizing the department to provide for additional members on the grievance review panel; amending s. 641.401, F.S.; providing an additional legislative purpose in regulating prepaid health clinics; amending s. 641.402, F.S.; providing a definition; amending s. 641.405, F.S.; providing additional requirements for persons applying for a certificate of authority from the Department of Insurance to operate a prepaid health clinic; requiring the Department of Health and Rehabilitative Services to adopt rules governing the operation of certain clinics providing prepaid health care and social services; amending s. 641.406, F.S.; providing additional requirements for obtaining a certificate of authority to operate a prepaid health clinic; amending s. 641.412, F.S.; requiring prepaid health clinics to pay an annual assessment; providing for deposit of assessment proceeds into the Health Care Services Trust Fund; creating s. 641.4185, F.S.; requiring periodic examinations of the quality of health care services provided by prepaid health clinics; exempting certain medical records and examination reports from public records law; providing for future legislative review of these exemptions pursuant to the Open Government Sunset Review Act; providing for subpoenas and enforcement thereof; providing a penalty; providing for the examination of prepaid health clinics that operate under certificates issued by the Department of Health and Rehabilitative Services prior to a specified date; creating s. 641.4187, F.S.; requiring prepaid health clinics to establish internal quality assurance programs; providing program requirements; prohibiting modification of the professional judgment of certain health care providers under certain circumstances; providing prepaid health clinic subscribers the right to a second medical opinion under certain circumstances; amending s. 641.45, F.S.; providing additional circumstances under which the department may revoke a clinic's certificate of authority; amending s. 641.455, F.S.; conforming provisions to changes made by the act; providing an appropriation and authorizing positions; saving existing rules adopted pursuant to part IV of ch. 641, F.S.; providing for a type four transfer of the regulation of health care services from the Department of Health and Rehabilitative Services to the Department of Insurance; requiring the Health Care Cost Containment Board to conduct a study on competition and provider contracts in health maintenance organizations; requiring a report; specifying the contents of the report; requiring the board to appoint a technical advisory panel; specifying panel membership and purposes; requiring state agencies and state officers to provide information and assistance; providing for reimbursement for per diem and travel expenses; repealing ss. 641.47, 641.48, 641.49, 641.495, 641.515, 641.52, 641.56, 641.57, 641.58, F.S., relating to health care services; reviving and readopting parts II and III of ch. 641, F.S., notwithstanding repeals scheduled pursuant to the Regulatory Sunset Act; providing for future review and repeal; providing an effective date.

House Amendment 1—On page 5, line 14, strike everything after the enacting clause and insert:

Part I
HEALTH MAINTENANCE ORGANIZATIONS

Section 1. Subsection (3) of section 641.48, Florida Statutes, is amended to read:

641.48 Purpose and application of part; exemption.—

(3) Any person or entity which enters into a contract with the department on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of health care services or social services, or both, to persons determined eligible for such services shall be exempt from the provisions of this part and shall be governed by the standards set forth by the department unless the person or entity provides health care service on a prepaid basis to persons other than those for which the department has contracted. However, any person or entity which is not *certified* ~~certificated~~ under the provisions of this chapter shall not use in its name, logo, contracts, or literature the phrases "health maintenance organization" or "prepaid health clinic" or the initials "HMO" or "PHC"; imply, directly or indirectly, that it is a health maintenance organization or prepaid health clinic; or hold itself out to be a health maintenance organization or prepaid health clinic. Subject to these restrictions, any such person or entity may advertise and market their prepaid health or social services using words or phrases similar to "prepaid health services" or "prepaid social services," so long as the services are accurately described and the advertisement and marketing literature clearly discloses that such services are available only to persons eligible for health care or social services through the department. The department shall set standards or promulgate rules for the conduct of a prepaid plan exempt under this subsection, which shall include provisions *whereby the entity shall* ~~for~~:

(a) Be organized primarily for the purpose of providing health care or other services of the type regularly offered to the department's enrolled clients.

(b)~~(a)~~ *Ensure that services meet the standards set by the department for* ~~The~~ quality, appropriateness, and timeliness ~~of services~~.

(c)~~(b)~~ *Make provisions satisfactory to the department for* insolvency protection and *ensure* ~~assurances~~ that neither *the department's* enrolled *clients* ~~recipients~~ nor the department shall be liable for the debts of the entity.

~~(c) A plan of operation which is actuarially sound and provides for working capital sufficient to carry all operating expenses for a period of 3 months.~~

(d) Submit to the department, if a private entity, a financial plan that the department finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets, excluding revenues from the department premium payments, equal to at least the first 3 months of operating expenses or $200,000, whichever is greater.

(e)~~(d)~~ *Furnish* evidence *satisfactory to the department* of adequate *liability* insurance coverage or an adequate plan of self-insurance to respond to claims *for injuries* arising out of the furnishing of *health care* ~~contracted services~~.

(f)~~(e)~~ *Provide, through contract or otherwise, for* periodic *review* ~~reviews~~ of its medical facilities, services, and records, *as required by the department.*

(g)~~(f)~~ *Provide* ~~Making available to the department~~ organizational, financial, and other *information* ~~data~~ that may be required to ensure quality of care and financial solvency.

Section 2. Subsection (10) of section 641.495, Florida Statutes, 1990 Supplement, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(10) The provisions of part I of chapter 395 do not apply to a health maintenance organization *if, on or before January 1, 1991, the organization* ~~that~~ provides not more than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members, provided such health maintenance organization maintains current accreditation by the Joint Commission on Accreditation of *Health Care Organizations,* ~~Hospitals (JCAH) or~~ the Accreditation Association for Ambulatory Health Care, *or the National Committee for Quality Assurance* ~~(AAAHC)~~.

Section 3. Section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.—

(1) The organization shall ensure that the health care services provided to subscribers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community.

(2) Each organization shall have an ongoing internal quality assurance program for its health care services. The program shall include, but not be limited to, the following:

(a) A written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;

(b) A written statement describing how state of the art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(c) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided;

(d) A written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization ~~and periodic review by an external review organization not less frequently than once every 3 years~~.

(3) The professional judgment of a physician licensed under *chapter 458, chapter 459, chapter 460, or chapter 461* ~~chapter 458 or chapter 459~~ concerning the proper course of treatment of a subscriber shall not be subject to modification by the organization or its board of directors, officers, or administrators, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. However, this subsection shall not be considered to restrict a utilization management program established by an organization.

(4)*(a)* Each organization shall give the subscriber the right to a second medical opinion in any instance in which the subscriber disputes the organization's *or the physician's* opinion of the reasonableness or necessity of surgical procedures or is subject to a *serious* ~~life threatening~~ injury or illness.

(b) The second opinion, if requested, is to be provided by a physician chosen by the subscriber *who may select:*

1. A contract or employed physician listed in a directory that shall be provided by the organization; or

2. A noncontract physician located in the same geographical service area of the organization.

(c) ~~For second opinions provided by a noncontract physician, the subscriber must use a physician located in the same geographical service area of the organization.~~ For second opinions provided by contract physicians the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the organization, but may require the subscriber to be responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a noncontract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section in the event the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber has unreasonably overutilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in ss. 641.495, ~~and~~ 641.311, *and 641.511.* The organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion shall be controlling as to the treatment obligations of the health maintenance organization. Treatment not authorized by the health maintenance organization shall be at the subscriber's expense.

Section 4. Section 641.511, Florida Statutes, is created to read:

641.511 Subscriber grievance reporting and resolution requirements.—

(1) The health maintenance organization shall maintain records of all grievances and shall report annually to the department a description of the total number of grievances handled, a categorization of the cases underlying the grievances, and the resolution of the grievances.

(2) Each health maintenance organization shall send to the department a copy of its annual and quarterly grievance reports submitted to the Department of Insurance pursuant to s. 641.311(1)(b).

(3) The department shall investigate all reports of unresolved quality of care grievances received from:

(a) Annual and quarterly grievance reports submitted by the health maintenance organization to the Department of Insurance.

(b) Appeals of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance procedure of the organization.

(4) The department shall advise subscribers with grievances to follow the health maintenance organization formal grievance process for resolution prior to review by the department. However, this shall not preclude the department from investigating any complaint prior to completion of the health maintenance organization's formal grievance process.

(5) A quality of care grievance which remains unresolved after a subscriber has followed the full grievance procedure of the organization, after review by the department, may be presented to the Statewide Subscriber Assistance Program Panel as set forth in s. 641.311.

Section 5. Section 641.512, Florida Statutes, is created to read:

641.512 Accreditation and external quality assurance assessment.—

(1)(a) To promote the quality of health care services provided by health maintenance organizations in this state, the department shall require each health maintenance organization to be accredited within 1 year of the organization's receipt of its certificate of authority and to maintain accreditation by an accreditation organization approved by the department, as a condition of doing business in the state.

(b) In the event that no accreditation organization can be approved by the department, the department shall require each health maintenance organization to have an external quality assurance assessment performed by a review organization approved by the department, as a condition of doing business in the state. The assessment shall be conducted within 1 year of the organization's receipt of its certificate of authority and every 2 years thereafter, or when the department deems additional assessments necessary.

(2) The accreditation or review organization must have nationally recognized experience in health maintenance organization activities and in the appraisal of medical practice and quality assurance in a health maintenance organization setting. The accreditation or review organization shall not currently be involved in the operation of the health maintenance organization nor in the delivery of health care services to its subscribers. The accreditation or review organization shall not have contracted or conducted consultations within the last 2 years for other than accreditation purposes of the health maintenance organization seeking accreditation or under quality assurance assessment.

(3) A representative of the department shall accompany the accreditation or review organization throughout the accreditation or assessment process, but shall not participate in the final accreditation or assessment determination. The accreditation or review organization shall monitor and evaluate the quality and appropriateness of patient care, the organization's pursuance of opportunities to improve patient care and resolve identified problems, and the effectiveness of the internal quality assurance program required for health maintenance organization certification pursuant to s. 641.49(3)(o).

(4) The accreditation or assessment process shall include a review of:

(a) All documentation necessary to determine the current professional credentials of employed health care providers or physicians providing service under contract to the health maintenance organization.

(b) At least a representative sample of not fewer than 50 medical records of individual subscribers. When selecting a sample, any and all medical records may be subject to review. The sample of medical records shall be representative of all subscribers' records.

(5) Every organization shall submit its books, documentations, and medical records and take appropriate action as may be necessary to facilitate the accreditation or assessment process.

(6) The accreditation or review organization shall issue a written report of its findings to the health maintenance organization's board of directors. A copy of the report shall be submitted to the department by the organization within 30 business days of its receipt by the health maintenance organization.

(7) The expenses of the accreditation or assessment process of each organization, including any expenses incurred pursuant to s. 641.512, shall be paid by the organization.

Section 6. Section 641.515, Florida Statutes, is amended to read:

641.515 Examination by the department.—

(1) The department *shall investigate further any quality of care issue contained in recommendations and reports submitted pursuant to ss. 641.311 and 641.511. The department shall also investigate further any information that indicates that the organization does not meet accreditation standards or the standards of the review organization performing the external quality assurance assessment pursuant to reports submitted under s. 641.512* ~~shall examine each organization, regarding the quality of health care services being provided by the organization, as often as it deems necessary for the protection of the people of this state, but not less frequently than once every 3 years.~~ Every organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. The department shall have access to the organization's medical records of individuals and records of employed *and contracted* physicians, *with the consent of the subscriber or by court order,* as necessary to carry out the provisions of this part. ~~These records shall also be made available to any outside source which conducts an examination pursuant to subsection (7).~~

~~(2) For the purpose of any examination conducted under this part, the Secretary of Health and Rehabilitative Services or the department's general counsel shall have the power to subpoena witnesses and compel their testimony, to subpoena the organization's medical records of individuals and records of employed health care providers, and, upon a showing of good cause, to subpoena medical records of subscribers from physicians providing service under contract to the organization, or other evidence which is relevant to the examination. Records obtained pursuant to this part shall be made available to any outside source which conducts an examination or investigation pursuant to subsection (7).~~

~~(3) If any person refuses to comply with any such subpoena or to testify as to any matter concerning which he may be lawfully interrogated, the circuit court of Leon County or of the county wherein such examination is being conducted, or of the county wherein such person resides, may, on the application of the department, issue an order requiring such person to comply with the subpoena and to testify.~~

(2)~~(4)~~ The examination report and the records obtained by the department or by an outside source pursuant to this section *and s. 641.512* shall be used solely for the purpose of the department in enforcing the requirements of this part and in disciplinary proceedings. These records and reports shall be otherwise sealed and shall not be available to the public pursuant to the provisions of s. 119.07 or any other statute providing access to public records. Further, these records and reports shall not be obtainable from the department through discovery or subpoena in civil actions.

~~(5) For the purpose of examinations, the department may administer oaths to and examine employees, officers, and agents of an organization concerning its business and affairs. The department may similarly examine nonemployee health care providers pursuant to subpoena issued by the secretary or the department's general counsel upon a showing of good cause under the provisions of this part.~~

~~(6) The expenses of examination of each organization by the department shall be paid by the organization, including any expenses incurred pursuant to subsection (7).~~

~~(7) The department may contract, at reasonable fees for work performed, with qualified, impartial outside sources to perform examinations or portions thereof pertaining to the qualification of an entity for issuance of a certificate or to determine continued compliance with the requirements of this part, including the examination of the quality of care provided. Any contracted assistance shall be under the direct supervision of the department. The results of any contracted assistance shall be subject to the review of and approval, disapproval, or modification by the department.~~

(3)~~(8)~~ If the department, through its examination or through any investigation, has a reasonable belief that conduct by a staff member or any other employee of an organization may constitute grounds for disciplinary action by the appropriate regulatory board, the department shall report this fact to such regulatory board.

(4) The department shall promulgate rules imposing upon physicians and hospitals performing services for a health maintenance organization standards of care generally applicable to physicians and hospitals. If the department determines that any physician or hospital is not adhering to such standards, it may immediately notify any health maintenance organization for which the physician or hospital performs services.

~~(9) In no event shall the expenses charged to any organization for examination under this section exceed $20,000 per year.~~

Section 7. Paragraph (g) is added to subsection (1) of section 641.52, Florida Statutes, to read:

641.52 Suspension, revocation of certificate; administrative fine; notice of action to the Department of Insurance; penalty for use of unlicensed providers.—

(1) The department may suspend the authority of an organization to enroll new subscribers or revoke the Health Care Provider Certificate of any organization, or order compliance within 60 days, if it finds that any of the following conditions exist:

(a) The organization is in substantial violation of its contracts.

(b) The organization is unable to fulfill its obligations under outstanding contracts entered into with its subscribers.

(c) The organization knowingly utilizes a provider who is furnishing or has furnished health care services and who does not have a subsisting license or other authority to practice or furnish health care services in this state.

(d) The organization no longer meets the requirements for the certificate as originally issued.

(e) The organization has violated any lawful rule or order of the department or any provision of this part.

(f) The organization has refused to be examined or to produce its accounts, records, and files for examination or to perform any other legal obligation as to such examination, when required by the department.

(g) The organization has not, after given reasonable notice, maintained accreditation or received favorable external quality assurance assessments pursuant to s. 641.512 or following an investigation pursuant to s. 641.515.

Section 8. *The Health Care Cost Containment Board is directed to conduct a study on competition and provider contracts in health maintenance organizations.*

(1) The board shall prepare and submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by December 15, 1991, a report addressing the following issues:

(a) The impact of competition, patient care, physician-patient relationships, and consumer choice on contract provisions which do not permit physicians to enter into contracts with other health maintenance organizations.

(b) The impact of competition, patient care, physician-patient relationships, and consumer choice on contract provisions which require a physician to make payment for liquidated damages when a physician terminates an agreement with a health maintenance organization and a subscriber elects to receive care from the same physician through another health maintenance organization.

(2) The report shall contain recommendations for any changes in state requirements for health maintenance provider contracts.

(3) The board shall appoint a technical advisory panel to conduct the study, which shall have representation from the following groups:

(a) A representative of elderly health care consumers.

(b) A representative of the physician community.

(c) Two representatives of the health maintenance organization industry.

(d) The Secretary of Health and Rehabilitative Services or his designee.

(e) The Commissioner of Insurance or his designee.

(f) A representative of the hospital industry.

(4) The board may procure information and assistance from any officer or agency of the state or any subdivision thereof. All such officers and agencies shall give the board all relevant information and reasonable assistance on any matters of research within their knowledge and control.

Section 9. *(1) Notwithstanding the provisions of the Regulatory Sunset Act or of any other provision of law which provides for review and repeal in accordance with s. 11.61, Florida Statutes, part IV of chapter 641, Florida Statutes, shall not stand repealed on October 1, 1991, and part IV of chapter 641, including each section which is added to part IV of chapter 641, Florida Statutes, by this act, is repealed on October 1, 2001, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.*

(2) This section shall take effect upon becoming a law.

Section 10. Except as otherwise provided herein, this part shall take effect October 1, 1991.

Part II
FLORIDA HEALTH CARE COMMISSION

Section 11. Effective April 1, 1992, the introductory paragraph and paragraph (c) of subsection (5) of section 20.19, Florida Statutes, 1990 Supplement, are amended to read:

20.19 Department of Health and Rehabilitative Services.—There is created a Department of Health and Rehabilitative Services.

(5) DEPUTY SECRETARY FOR PROGRAMS.—The secretary shall appoint a Deputy Secretary for Programs who shall serve at the pleasure of, and be directly responsible to, the secretary. The secretary shall appoint a Deputy Assistant Secretary for Programs~~, an Assistant Secretary for Regulation and Health Facilities,~~ and an Assistant Secretary for Medicaid, each of whom shall serve at the pleasure of the secretary and shall be directly responsible to the Deputy Secretary for Programs.

~~(c) The responsibilities of the Assistant Secretary for Regulation and Health Facilities shall include, but are not limited to, certificate of need determinations, Hill Burton programs, and licensure and certification of programs external to the department for which the department has a major regulatory responsibility. The deputy secretary may assign or delegate other responsibilities of this office in keeping with the intent of this act.~~

Section 12. *Except as otherwise provided in this act, all powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Assistant Secretary for Regulation and Health Facilities of the Department of Health and Rehabilitative Services are transferred by a type three transfer, as defined in s. 20.06(3), Florida Statutes, to the Health Care Commission. Such transfer shall take effect April 1, 1992. Any rules promulgated by or for the Assistant Secretary for Regulation and Health Facilities are included in such transfer.*

Section 13. Effective April 1, 1992, paragraphs (c), (d), and (g) of subsection (3) of section 381.0612, Florida Statutes, 1990 Supplement, are amended to read:

381.0612 State Center for Health Statistics.—

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to produce comparable and uniform health information and statistics, the *commission* ~~department~~ shall perform the following functions:

(c) Review the statistical activities of the Department *of Health and Rehabilitative Services* to assure that they are consistent with the comprehensive health information system.

(d) Develop written agreements with local, state, and federal agencies for the sharing of health-care-related data or using the facilities and services of such agencies. State agencies, local health councils, and other agencies under contract with the Department *of Health and Rehabilitative Services* shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center.

(g) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data. The *commission* ~~department~~ shall periodically review ongoing health care data collections of the Department *of Health and Rehabilitative Services* and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.

Section 14. *Except as otherwise provided in this act, all powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the State Center for Health Statistics of the Department of Health and Rehabilitative Services are transferred by a type one transfer, as defined in s. 20.06(1), Florida Statutes, to the Health Care Commission and assigned to the Bureau of Data Management of the commission, as created by this act. Such transfer shall take effect on April 1, 1992. Any rules promulgated by or for the center are included in such transfer.*

Section 15. Effective April 1, 1992, subsection (11) of section 381.609, Florida Statutes, 1990 Supplement, is amended to read:

381.609 Testing for human immunodeficiency virus.—

(11) TESTING AS A CONDITION OF TREATMENT OR ADMISSION.—

(a) It is unlawful for any facility the operation of which, or for any person engaged in an occupation the practice of which, requires a license by the Department of Health and Rehabilitative Services, *the Health Care Commission,* or the Department of Professional Regulation, to require any person to take or submit to a human immunodeficiency virus-related test as a condition of admission to any such facility or as a condition of purchasing or obtaining any service or product for which the license is required. This subsection shall not be construed to prohibit any physician in good faith from declining to provide a particular treatment requested by a patient if the appropriateness of that treatment can only be determined through a human immunodeficiency virus-related test.

(b) The Department of Health and Rehabilitative Services, *the Health Care Commission,* and the Department of Professional Regulation shall adopt rules implementing this section.

(c) Any violation of this section or the rules implementing it shall be punishable as provided in subsection (6).

Section 16. *Effective April 1, 1992, sections 381.701 through 381.714, Florida Statutes, and section 381.715, Florida Statutes, 1990 Supplement, are renumbered as sections 408.301 through 408.315, respectively, and designated as part II of chapter 408, Florida Statutes.*

Section 17. Effective April 1, 1992, section 381.709, Florida Statutes, is renumbered as section 408.309, Florida Statutes, and paragraph (d) of subsection (4), subsection (5), and paragraph (a) of subsection (6) of said section are amended, to read:

408.309 ~~381.709~~ Review process.—The review process for certificates of need shall be as follows:

(4) STAFF RECOMMENDATIONS.—

(d) If no ~~administrative~~ hearing is requested pursuant to subsection (5), the State Agency Action Report and the Notice of Intent shall become the final order of the *commission* ~~department~~. The *commission* ~~department~~ shall provide a copy of the final order to the appropriate local health council.

(5) ~~ADMINISTRATIVE~~ HEARINGS.—

(a) Within 21 days after publication of notice of the State Agency Action Report and Notice of Intent, any person authorized under paragraph (b) to participate in a hearing may file a request for ~~an administrative~~ hearing; failure to file a request for hearing within 21 days of publication of notice shall constitute a waiver of any right to a hearing and a waiver of the right to contest the final decision of the *commission* ~~department~~. A copy of the request for hearing shall be served on the applicant.

(b) Hearings shall be held in Tallahassee unless the *chairman* ~~hearing officer~~ determines that changing the location will facilitate the proceedings. In ~~administrative~~ proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the *commission* ~~department~~ in the same batching cycle are entitled to a comparative hearing on their applications. Existing health care facilities may initiate or intervene in such ~~administrative~~ hearing upon a showing that an established program will be substantially affected by the issuance of a certificate of need to a competing proposed facility or program within the same district, provided that existing health care providers, other than the applicant, have no standing or right to initiate or intervene in *a* ~~an administrative~~ hearing involving a health care project which is subject to certificate-of-need review solely on the basis of s. *408.306(1)(c)* ~~381.706(1)(c)~~. The *chairman* ~~department~~ shall assign proceedings *to a panel of commissioners* ~~requiring hearings to the Division of Administrative Hearings of the Department of Administration~~ within 10 days after the time has run to request a hearing. Except upon unanimous consent of the parties or upon the granting by the *chairman* ~~hearing officer~~ of a motion of continuance, hearings shall commence within 60 days after the *commissioners have* ~~hearing officer has~~ been assigned. All nonstate-agency parties shall bear their own expense of preparing a transcript. In any application for a certificate of need, *the presiding commissioner shall, within 30 days after the hearing or receipt of the hearing transcript, whichever is later, file a recommended order which shall include findings of fact and conclusions of law, separately stated, and recommendation for final commission action. The commission* ~~which is referred to the Division of Administrative Hearings for hearing, the hearing officer shall complete and submit to the parties a recommended order as provided in s. 120.57(1)(b). The recommended order shall be issued within 30 days after the receipt of the proposed recommended orders or the deadline for submission of such proposed recommended orders, whichever is earlier. The division~~ shall adopt procedures for ~~administrative~~ hearings which shall maximize the use of stipulated facts and shall provide for the admission of prepared testimony.

(c) The *commission* ~~department~~ shall issue its final order within 45 days after receipt of the recommended order~~.~~ *after providing participants opportunity to file exceptions. Exceptions shall be filed within 14 days of service of the recommended order. A party's failure to serve or file timely written exceptions shall constitute a waiver of any objections to the recommended order.*

(d) Any party to a proceeding who is adversely affected by an order of the commission may file a motion for reconsideration of that order. A final order shall not be deemed rendered for the purpose of judicial review until the commission disposes of any motion, but this provision does not serve automatically to stay the effectiveness of any such final order. A motion for reconsideration of a final order shall be filed within 15 days of service of the final order.

(e) ~~(d)~~ If the *commission* ~~department~~ fails to take action within the time specified in paragraph (4)(a) or paragraph (5)(c), or as otherwise agreed to by the applicant and the *commission* ~~department~~, the applicant may take appropriate legal action to compel the *commission* ~~department~~ to act. When making a determination on an application for a certificate of need, the *commission* ~~department~~ is specifically exempt from the time limitations provided in s. 120.60(2).

(6) JUDICIAL REVIEW.—

(a) A party to *a* ~~an administrative~~ hearing for an application for a certificate of need has the right, within not more than 30 days after the date of the final order, to seek judicial review in the District Court of Appeal pursuant to s. 120.68. The *commission* ~~department~~ shall be a party in any such proceeding.

Section 18. Effective April 1, 1992, section 381.7155, Florida Statutes, is renumbered as section 408.3155, Florida Statutes, and amended to read:

408.3155 ~~381.7155~~ Effect of ss. *408.301-408.315* ~~381.701-381.715 as enacted by chapter 87-92, Laws of Florida; rules~~; health councils and plans; pending proceedings.—

(1) Nothing contained in ss. *408.301-408.315* ~~381.701-381.715~~ is intended to repeal or modify any of the existing rules of the Department of Health and Rehabilitative Services, *which shall remain in effect and shall be enforceable by the commission;* the existing composition of the local health councils and the Statewide Health Council~~,~~; or the state health plan~~,~~; or any of the local district health plans, unless, and only to the extent that, there is a direct conflict with the provisions of ss. *408.301-408.315* ~~381.701-381.715~~.

(2) The rules of the Department of Health and Rehabilitative Services in effect on July 1, 1987, which implement the provisions of ss. 381.493-381.499, shall remain in effect and shall be enforceable by the *commission* ~~department~~ until such rules are repealed or amended by the *commission* ~~department~~, and no judicial or administrative proceeding pending on July 1, 1987, shall be abated as a result of the provisions of ss. *408.301-408.313(1), (2); s. 408.314; or s. 408.315* ~~381.701-381.713(1), (2), (3); s. 381.714; or s. 381.715~~.

Section 19. *All certificates of need valid on April 1, 1992, shall remain in full force and effect. On and after April 1, 1992, applications for certificates of need shall be made in accordance with the provisions of this act.*

Section 20. Effective April 1, 1992, paragraphs (c) and (f) of subsection (3) and subsection (4) of section 395.017, Florida Statutes, 1990 Supplement, are amended to read:

395.017 Patient and personnel records; copies; examination.—

(3) Patient records shall be confidential and shall not be disclosed without the consent of the person to whom they pertain, but appropriate disclosure may be made without such consent to:

(c) The *commission* ~~Health Care Cost Containment Board~~.

(f) The *commission* ~~department~~ or its agent, for the purpose of establishing and maintaining a trauma registry and for the purpose of ensuring that hospitals and trauma centers are in compliance with the standards and rules established pursuant to ss. 395.031, 395.032, 395.035, and 395.036, and for the purpose of monitoring patient outcome at hospitals and trauma centers which provide trauma care services.

(4) The *commission* ~~department~~ may examine patient records of a licensed facility for the purpose of epidemiological investigations, provided that the unauthorized release of information by agents of the *commission* ~~department~~ which would identify an individual patient constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 21. Effective April 1, 1992, subsections (4) through (8), (10), and (12) through (14) of section 395.041, Florida Statutes, 1990 Supplement, are amended to read:

395.041 Internal risk management program.—

(4) The *commission* ~~Department of Health and Rehabilitative Services~~ shall, after consulting with the Department of Insurance, promulgate rules governing the establishment of such internal risk management programs to meet the needs of individual establishments. The Department of Insurance shall assist the *commission* ~~Department of Health and Rehabilitative Services~~ in preparing such rules. Each internal risk management program shall include the use of incident reports to be filed with

an individual of responsibility who is competent in risk management techniques in the employ of each establishment, such as an insurance coordinator, or who is retained by said establishment as a consultant. Said individual shall have free access to all establishment medical records, and the rules promulgated by the *commission* ~~Department of Health and Rehabilitative Services~~ shall so provide. The incident reports shall be considered to be a part of the workpapers of the attorney defending the establishment in litigation relating thereto and shall be subject to discovery, but shall not be admissible as evidence in court, nor shall any person filing an incident report be subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports shall be utilized to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct said problem areas.

(5)(a) Each licensed facility subject to this section shall submit a quarterly report to the *commission* ~~department~~ summarizing the incident reports that have been filed in the facility for that quarter. The report shall be on a form prescribed by rule of the *commission* ~~department~~ and shall include:

1. The total number of adverse incidents causing injury to patients.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. A code number utilizing the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents causing injury to patients, the relationship of the individual to the facility, and the number of incidents in which each individual has been directly involved. Each facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all malpractice claims filed against the facility, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.

6. A report of all disciplinary actions pertaining to patient care taken against any medical staff member, including the nature and cause of the action.

(b) The information reported to the *commission* ~~department~~ pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall also be reported to the Department of Professional Regulation on a quarterly basis. The Department of Professional Regulation shall review the information and determine whether any of the incidents potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(c) The report submitted to the *commission* ~~department~~ shall also contain the name of the risk manager of the facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse or untoward incidents, and the results of such measures. The quarterly reports shall be held confidential and shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the *commission* ~~department~~, the Department of Professional Regulation, and the appropriate regulatory board. The quarterly reports shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the *commission* ~~department~~, the Department of Professional Regulation, or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

(6) If an adverse or untoward incident, whether occurring in the facility or arising from health care prior to admission in the facility, results in:

(a) The death of a patient;

(b) Severe brain or spinal damage to a patient;

(c) A surgical procedure being performed on the wrong patient; or

(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient,

the facility shall report this incident to the *commission* ~~department~~ within 15 calendar days of its occurrence. The *commission* ~~department~~ may require an additional, final report. Reports under this subsection shall be sent immediately by the *commission* ~~department~~ to the Department of Professional Regulation whenever they involve a health care provider licensed under chapter 458, chapter 459, chapter 461, or chapter 466. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the *commission* ~~department~~, the Department of Professional Regulation, and the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The *commission* ~~department~~ may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The Department of Professional Regulation shall review each incident and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(7) In addition to any penalty imposed pursuant to s. 395.018, the *commission* ~~department~~ may impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of subsection (5) or subsection (6). This subsection shall take effect July 1, 1989.

(8) The *commission* ~~department~~ and, upon subpoena issued pursuant to s. 455.223, the Department of Professional Regulation shall have access to all facility records necessary to carry out the provisions of this section. The records obtained are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the *commission* ~~department~~, the Department of Professional Regulation, and the appropriate regulatory board, nor shall records obtained pursuant to s. 455.223 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, the provisions of s. 766.101 shall control.

(10) The *commission* ~~department~~ shall review, no less than annually, the risk management program at each facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5) and (6).

(12) If the *commission* ~~department~~, through its receipt of the annual reports prescribed in subsection (5) or through any investigation, has a reasonable belief that conduct by a staff member or employee of a facility may constitute grounds for disciplinary action by the appropriate regulatory board, the *commission* ~~department~~ shall report this fact to such regulatory board.

(13) The *commission* ~~department~~ shall send information bulletins to all facilities as necessary to disseminate trends and preventative data derived from its actions under this section. The gross data compiled shall be furnished by the *commission* ~~department~~ upon request to facilities to be utilized for risk management purposes.

(14) The *commission* ~~department~~ may promulgate rules necessary to carry out the provisions of this section.

Section 22. Effective April 1, 1992, paragraph (d) of subsection (2), paragraph (f) of subsection (3), paragraph (b) of subsection (5), and subsections (4) and (10) of section 400.304, Florida Statutes, are amended to read:

400.304 Establishment of a State Nursing Home and Long-Term Care Facility Ombudsman Council; duties; membership.—

(2) In order to ensure that the ombudsman program has the objectivity and independence required to qualify it for funding under the federal Older Americans Act, the State Unit on Aging of the Department of Health and Rehabilitative Services shall contract with the Commission on Aging for the operation of an Office of the State Long-Term Care Ombudsman to carry out the long-term care ombudsman program and advise the state and district councils. The contract shall be limited to provisions which assure compliance with and carry out the intent of the Older Americans Act. The State Unit on Aging shall:

(d) Submit annually to the Legislature a report of the status of the contract with the Commission on Aging, including a statement regarding any problems in the contractual arrangement; an assessment of the success of the ombudsman program during the preceding year; the degree of compliance by the program with the Older Americans Act; and an assessment of the level of cooperation between *the Health Care Commission,* the Department of Health and Rehabilitative Services, and the ombudsman program regarding shared responsibilities, including, but not limited to, access to records and actions taken on behalf of residents of long-term care facilities. The report shall be submitted in conjunction with the report submitted by the state ombudsman council required by this section. The first report shall be submitted to the Legislature on or before March 1, 1990.

(3) The state ombudsman council:

(f) Shall prepare an annual report to the President of the Senate, the Speaker of the House, and the Governor containing an appraisal of the problems of nursing home and long-term care facility residents, recommendations for improving nursing home and long-term care facility care and treatment, and an analysis of the success of the ombudsman program during the preceding year which should address, at a minimum, the relationship between the ombudsman program, *the Health Care Commission,* the Commission on Aging, and the Department of Health and Rehabilitative Services and an assessment of how successfully the ombudsman program has carried out its responsibilities under the Older Americans Act. The annual report shall be submitted on or before March 1 of each year.

(4) In performing the duties specified in state and federal law, the ombudsman councils shall be independent of *the Health Care Commission and* the Department of Health and Rehabilitative Services. However, *the commission,* the department, and the councils shall cooperate fully in the discharge of their responsibilities for identifying and correcting deficiencies in nursing homes and other long-term care facilities.

(5) The state ombudsman council shall be composed of 12 members appointed by the Governor. The council shall solicit nominations from appropriate professional organizations, consumer groups representing older or disabled persons and long-term care advocacy groups, and shall submit a list of nominees to the Governor for consideration.

(b) In no case may the medical director of a nursing home or a long-term care facility or an employee of *the Health Care Commission or* the Department of Health and Rehabilitative Services serve as a member or as an ex officio member of the council. Except for the nursing home administrator, adult congregate living facility owner or operator, medical or osteopathic physician, licensed pharmacist, registered dietitian, and registered nurse, each member of the state ombudsman council shall certify to having no association with a nursing home or long-term care facility for reward or profit.

(10) The state ombudsman council is authorized to call upon appropriate agencies of state government for such professional assistance as may be needed in the discharge of its duties, including assistance from any adult protective services programs of the Department *of Health and Rehabilitative Services* as provided for under s. 409.026 and ss. 415.101-415.113.

Section 23. Effective April 1, 1992, subsections (1) and (4) of section 400.307, Florida Statutes, are amended to read:

400.307 District nursing home and long-term care facility ombudsman councils; duties; membership.—

(1) There shall be at least one nursing home and long-term care facility ombudsman council in each of the districts of the Department *of Health and Rehabilitative Services,* which shall function under the direction of the state ombudsman council.

(4) Each district ombudsman council shall be composed of no less than 15 members and no more than 20 members from the district, to include the following: one medical or osteopathic physician whose practice includes or has included a substantial number of geriatric patients and who may have limited practice in a long-term care facility; one registered nurse who has geriatric experience, if possible; one nursing home administrator; one owner or operator of an adult congregate living facility; one licensed pharmacist; one registered dietitian; at least five nursing home residents or representative consumer advocates for nursing home residents; at least two long-term care facility residents or representative consumer advocates for long-term care facility residents; one attorney; and one professional social worker. In no case shall the medical director of a nursing home or a long-term care facility or an employee of *the Health Care Commission or* the Department of Health and Rehabilitative Services serve as a member or as an ex officio member of a council. Except for the nursing home administrator, adult congregate living facility owner or operator, medical or osteopathic physician, licensed pharmacist, registered dietitian, and registered nurse, each member of the council shall certify to having no association with a nursing home or long-term care facility for reward or profit. Any member who has an affiliation with a nursing home, adult congregate living facility, or adult foster home may not participate in any investigation or inspection of any facility with which he has such affiliation.

Section 24. Effective April 1, 1992, subsection (2) of section 400.401, Florida Statutes, is amended to read:

400.401 Short title; purpose.—

(2) The purpose of this act is to provide for the health, safety, and welfare of residents of adult congregate living facilities in the state, to promote continued improvement of such facilities, to encourage the development of innovative and affordable facilities particularly for persons with low to moderate incomes, to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of *the Health Care Commission,* the Department of Health and Rehabilitative Services, adult congregate living facilities, and other community agencies. The Legislature recognizes that adult congregate living facilities are an important part of the continuum of long-term care in the state. The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible in order that premature nursing home or institutional placement may be avoided.

Section 25. Effective April 1, 1992, subsections (2) and (3) of section 400.408, Florida Statutes, are amended to read:

400.408 Referral of person for residency to unlicensed facility; penalty; verification of licensure status.—

(2) In at least one office in each district of the Department *of Health and Rehabilitative Services,* the *commission* ~~department~~ shall maintain a list of licensed facilities within that district and shall update the list at least monthly.

(3) At least annually, the *commission* ~~department~~ shall notify, in writing, every physician licensed pursuant to chapter 458, every osteopathic physician licensed pursuant to chapter 459, every hospital licensed pursuant to part I of chapter 395, every nursing home facility licensed pursuant to part I of this chapter, and every employee of the Department *of Health and Rehabilitative Services* having a responsibility for referring persons for residency that it is unlawful to knowingly refer a person for residency to an unlicensed adult congregate living facility and shall notify them of the penalty for violating such prohibition. Further, the notice must direct each noticed facility and individual to contact the *commission* ~~appropriate departmental office~~ in order to verify the licensure status of any facility prior to referring any person for residency. Each notice must include the name, telephone number, and mailing address of the appropriate office to contact.

Section 26. Effective April 1, 1992, section 400.623, Florida Statutes, is amended to read:

400.623 Recruitment.—The *commission* ~~department~~ shall recruit and license an appropriate number of adult foster homes to serve the ~~department's~~ clients *of the Department of Health and Rehabilitative Services.* When a licensed adult foster home accepts more than one resident not placed in the home by the Department *of Health and Rehabilitative Ser-*

vices, the *commission* ~~department~~ shall cancel the license issued pursuant to this section and require the home to make application for licensure as an adult congregate living facility in accordance with the provisions of part II of this chapter.

Section 27. Effective March 1, 1992, part I of chapter 408, Florida Statutes, consisting of sections 408.001, 408.01, 408.02, 408.025, 408.03, 408.04, 408.05, 408.06, 408.07, 408.08, 408.10, 408.11, 408.12, 408.20, 408.21, 408.22, 408.23, 408.24, 408.25, 408.26, and 408.27, is created to read:

408.001 Florida Health Care Commission.—

(1) LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that Florida is lacking a rational, continuous, and coordinated health planning and policy development process. Responsibility for health policy development and for the enforcement of this policy is dispersed throughout state and local government, and no single executive agency has been given authority for the coordination of health policy development. The Legislature further finds that, in expressing its ultimate authority as policymaker for the state, the Legislature has enacted conflicting health goals and objectives. Although programs have been enacted to regulate hospital reimbursement, health care capital expenditures, health financing, and the licensing of health professionals and facilities, and to establish planning and data management, there is little coordination among these activities, nor is there an overall policy directive for these programs. Therefore, it is the intent of the Legislature to establish a single state agency with overall responsibility for the state's health care planning, regulation, and policy development.

(2) CREATION OF COMMISSION; COMPREHENSIVE HEALTH PLAN.—The Florida Health Care Commission is hereby established as the single state agency with responsibility for all health regulation, health planning in conjunction with local governments, and the development of a health care data base. The commission shall be responsible for the planning, regulation, and data management of health care as established in this act. In meeting this responsibility, the commission shall consult with the State University System and independent health and medical professional schools. Further, the commission shall assist the Legislature in health policy development through the establishment of an integrated, rational, and comprehensive health plan. The plan shall contain health policy goals and objectives relating to health care cost containment, access to health care, and health care quality and shall be developed and updated in incremental steps. Included in the plan shall be specific proposals for regulatory policy to be considered by the Legislature for each of the areas under the commission's jurisdiction. Prior to developing its recommendations to the Legislature for reaching each health care goal, the commission shall conduct public hearings to permit interested parties the opportunity to provide input. The commission's proposals shall be submitted to the Legislature according to the schedule set forth in this act or as part of the Sunset Review process.

408.01 Health Care Commission goals.—The Legislature hereby establishes goals and objectives for the commission, to serve as a guide in the development of health policy recommendations to the Legislature. The commission is directed to achieve the health goals as set forth below:

(1) HEALTH CARE COST CONTAINMENT.—

(a) Legislative findings; goal.—Despite numerous efforts by the Legislature for at least the last decade to curb health spending, health care costs continue to increase at an unacceptable rate. The increase in health care costs is of concern to the Legislature not only because increasing costs threaten the ability of the private sector and state and local governments to pay for health care, but also because rapid cost escalations threaten the ability of Florida business to compete in national and international markets. Therefore, the Legislature hereby establishes the following cost containment goal: By the year 1996, per capita health care costs should be increasing by no more than the consumer price index. In addition, no single component of the health care system, be it capital expenditures for new beds or services, or the rate of increase in per capita spending for hospital or physician services, pharmacy, or long term care services, may increase faster on an annual basis than the consumer price index, unless such increase is vital to meeting a health priority as recommended by the commission.

(b) Plan.—By January 1, 1994, the commission shall submit to the Legislature and the Governor a plan for accomplishing the cost containment goal. This plan shall include a component related to the containment of costs associated with: capital expenditures, provider reimbursement, facility reimbursement, and health financing through the local and state health facilities financing authorities. The plan shall also include specific proposals in the form of draft legislation, as needed, for: reducing the cost of medical liability insurance; reforms to the tort system as it relates to medical care; and the establishment of practice parameters. In developing the cost containment plan, the commission shall rely on the use of market forces where such forces have in the past proven effective in containing health care costs. In those areas where market forces have not proven effective in containing costs, the commission shall rely upon regulatory strategies or other strategies which, in the commission's opinion, have the greatest prospect of proving effective in meeting the cost containment goal. It is the intent of the Legislature that, to the extent possible, the free enterprise system for the delivery of health services shall be preserved. However, the Legislature recognizes that managed care programs, regulated fee schedules for physicians and other practitioners, a statewide prospective payment system such as diagnostic related groups for all payers, the establishment of a health care budget for Florida, establishing aggregate total capital expenditure limits, or other related efforts may be necessary in order to accomplish the cost containment goal. In establishing its plan for cost containment, the commission shall include those cost containment mechanisms which are, in priority order from greatest to least priority, most likely to achieve the desired cost containment goal, least administratively complex, and least intrusive on private sector health care providers. All components of the health care system shall be included in the commission's health care cost containment plan.

(2) HEALTH CARE ACCESS.—

(a) Legislative findings; goal.—Access to health care is an increasing problem for many Floridians, especially for women and young children, part-time employees and employees of small businesses, and the unemployed. Failure of our health care system to provide access to all is not only unacceptable to the Legislature for humanitarian reasons, but also because it results in inappropriate and far more costly use of health resources, a less productive work force, and a less effective educational system. Therefore, the Legislature hereby establishes the following health care access goal: All Floridians should have access to primary health care by 1996.

(b) Plan.—By January 1, 1994, the commission shall submit to the Legislature and the Governor a plan for accomplishing the health care access goal. The plan shall address all aspects of the health care access problem and shall include a consideration of at least the following:

1. The role state and local government should assume in the provision of health services, including level of service, sources of funding, and delivery system models. By the year 1996, state and local governments, in cooperation with the private sector, shall ensure that all unemployed, low-income persons have access to primary health care services.

2. The role employers should assume, including whether employer mandates are needed to ensure access and the form such mandates should take. The plan should ensure that, by 1996, employees and their dependents have, at a level acceptable to the Legislature, primary health coverage or employers may be mandated to provide such coverage. However, in no event shall the Legislature consider any system of employer mandated health care coverage unless the Legislature finds that the cost containment goal has been met and mandated coverage is still necessary. The implementing legislation shall consider the potential impact on employment levels and shall provide a mechanism through appeal to the commission for an exemption to mandated coverage upon a showing of hardship.

3. The role and responsibilities which each individual should assume in obtaining access to health care.

4. A mechanism to ensure coordination among programs, and an appropriate organizational structure for implementation and plan administration.

5. Reforms needed in insurance regulation, including mechanisms to ensure that any cost savings achieved by such reforms will result in lower insurance premiums.

6. The health coverage component of workers' compensation, personal injury protection, and other existing health coverage for possible consolidation into a single comprehensive health benefit plan.

7. Measures needed to ensure an adequate supply and distribution of health manpower, including, but not limited to, determining whether to expand licensure and reciprocity laws to provide for practice in the state by health care professionals licensed by other states.

8. The advantages and disadvantages of establishing a two-tier system of health care versus a system where all users have equal access regardless of economic status, and recommendations regarding which model best suits Florida.

9. Placing appropriate limitations on the liability exposure of physicians when treating indigent patients at no charge.

The commission shall include in its health care access plan a recommendation for the prioritization of various categories of health care services. In developing a priority plan, the commission shall consider the cost effectiveness of the service, how the service will contribute to the quality of life, and the humanitarian nature of the service. In developing this priority plan, the commission shall utilize persons with expertise in ethics, medicine, religion, and philosophy.

(3) HEALTH CARE QUALITY.—

(a) Legislative findings; goal.—The Legislature has committed significant resources to the collection and dissemination of health care cost data, but to date little has been done to evaluate the quality of health care. In a time of diminishing resources and increasing demands, it is essential that the quality of health services be evaluated. Therefore, the Legislature hereby establishes the following health care quality goal: By 1996, there shall be in place a mechanism to collect, evaluate, and disseminate information regarding the quality of health services. The commission shall publish annually an evaluation of the quality of health care services in hospitals and other health care facilities, and the quality of care given by physicians. The quality of care data shall be of a nature to evaluate the quality of care within medical and health care specialities, and to evaluate the efficacy of one modality of treatment versus other modalities of treatment. The Commission should encourage the use of nationally developed medical practice guidelines and outcomes research to measure and improve the quality of care and determine the appropriateness of medical procedures.

(b) Plan.—By January 1, 1995, the commission shall submit to the Legislature and the Governor a plan for accomplishing the health care quality goal.

(4) HEALTH PLANNING.—

(a) Legislative findings; goal.—The Legislature finds that in order to redesign the health care delivery system and to administer the redesigned system, broad input is needed from all levels, including state and local government, health providers, health consumers, health purchasers, and the general public. Mechanisms to accomplish health planning have been established in the past, but the Legislature finds that these mechanisms have been ineffective in accomplishing a rational, comprehensive, and coordinated health planning system. Therefore, the Legislature establishes the following health planning goal: By 1995, there shall be created in Florida a rational, comprehensive, and coordinated system of health planning which involves input from all aspects of the health care system, including government, purchasers, providers, consumers, business, and the general public.

(b) Plan.—By January 1, 1993, the commission shall submit to the Legislature and the Governor a plan for accomplishing the health planning goal. The plan shall ensure that all constituencies are represented in the planning process, but that no single constituency is overrepresented. In addition, the plan shall include, but not be limited to:

1. A mechanism to ensure that health planning is integrated with all other state and local comprehensive planning.

2. Concise duties and responsibilities for local and statewide health planning.

408.02 Location of commission; appointment of commissioners; commission proceedings.—

(1) The Health Care Commission shall be located within the Department of Health and Rehabilitative Services for administrative purposes. However, the commission shall be a separate budget entity and shall not be subject to control, supervision, or direction by the department in any manner, including, but not limited to, personnel, purchasing, transactions involving real or personal property, and budgetary matters. The department shall provide reasonable administrative support and services to the commission to the extent requested by the commission chairman, who shall be the agency head of the commission for all purposes.

(2) The Governor shall appoint five commissioners who have demonstrated knowledge and expertise in Florida's health care system to the Health Care Commission, subject to confirmation by the Senate. If the Senate refuses to confirm or rejects any appointment, the Governor shall make a new appointment within 30 days. Commissioners may be appointed according to the following criteria:

(a) One commissioner may be a member of The Florida Bar who has expertise in health law.

(b) One commissioner may be a physician licensed under chapter 458 or chapter 459.

(c) One commissioner may have expertise in hospital management.

(d) One commissioner may have expertise in health insurance.

(e) One commissioner may be a consumer of health care.

(3)(a) Each appointment to the commission shall be for a 4-year term, except that to ensure a staggering of terms, the initial term for one commissioner shall expire on January 1, 1994, the initial term for two commissioners shall expire on January 1, 1995, and the initial term for two commissioners shall expire on January 1, 1996.

(b) If a vacancy is created on the commission, the vacancy shall be filled within 120 days from the date the vacancy occurs, and the appointment shall be valid for the remainder of the unexpired term.

(4)(a) The initial appointment of commissioners shall be completed by March 1, 1992, at which time the commissioners shall assume the duties of the commission.

(b) The commission shall develop a plan for the administrative organization and operation of the commission, to take effect on April 1, 1992. The plan shall provide for integrating existing operations into the commission and for staffing and funding the operations of the commission.

(5) Any person serving on the commission who seeks to be reappointed shall submit to the Governor, at least 120 days before the expiration of his term, a statement that he desires to serve an additional term.

(6) By May 1, 1992, one member of the commission shall be elected by majority vote to serve as chairman until December 31, 1993. Thereafter, one member of the commission shall be elected by majority vote to serve as chairman for a term of 2 years, beginning January 1, 1994. A member may not serve two consecutive terms as chairman.

(7) The primary duty of the chairman is to serve as chief administrative officer of the commission. However, the chairman may participate in any proceedings pending before the commission when administrative duties and time permit. In order to distribute the workload and expedite the commission's calendar, the chairman, in addition to other administrative duties, has authority to assign the various proceedings pending before the commission requiring hearings to two or more commissioners. Only those commissioners assigned to a proceeding requiring hearings are entitled to participate in the final decision of the commission as to that proceeding. However, if only two commissioners are assigned to a proceeding requiring hearings and cannot agree on a final decision, the chairman shall cast the deciding vote for final disposition of the proceeding. If more than two commissioners are assigned to any proceeding, a majority of the members assigned shall constitute a quorum and a majority vote of the members assigned shall be essential to final commission disposition of those proceedings requiring actual participation by the commissioners. If a commissioner becomes unavailable after assignment to a particular proceeding, the chairman shall assign a substitute commissioner. In those proceedings assigned to a hearing examiner, following the conclusion of the hearings, the designated hearing examiner is responsible for preparing recommendations for final disposition by a majority vote of the commission. A petition for reconsideration shall be voted upon by those commissioners participating in the final disposition of the proceeding.

(8) A majority of the commissioners may determine that the full commission shall sit in any proceeding. The Public Counsel or a person regulated by the Health Care Commission and substantially affected by a proceeding may file a petition that the proceeding be assigned to the full commission. Within 15 days of receipt by the commission of any petition or application, the full commission shall dispose of such petition by majority vote and render a written decision thereon prior to assignment of less than the full commission to a proceeding. In disposing of such petition, the commission shall consider the overall general public interest and impact of the pending proceeding, including, but not limited to, the following criteria: the magnitude of the proposed project, including the number of consumers affected; the amount of resources to be expended; the services rendered to the affected public; the needs of the affected consumers in the area to be served; regulatory policies; competition; and the precedential nature of the proposed project and its potential impact on overall health policy. If the petition is denied, the commission shall set forth the grounds for denial.

(9) This section does not prohibit a commissioner designated by the chairman from conducting a hearing as provided under s. 120.57(1) or s. 350.631, and any rules of the commission adopted pursuant thereto.

408.025 Organizational structure.—

(1) The commission shall employ an executive director, who shall serve at the pleasure of the commission. The executive director shall appoint a general counsel, and shall employ other staff as approved by the commission.

(2) The following divisions are established within the commission:

(a) The Division of Licensure, within which the following bureaus are established:

1. The Bureau of Facility Licensure.

2. The Bureau of Professional Licensure, which shall have responsibility for each profession regulated by the commission.

(b) The Division of Planning and Policy Development, within which the following bureaus are established:

1. The Bureau of Technical Assistance.

2. The Bureau of Data Management.

3. The Bureau of Planning.

(c) The Division of Financial Management, within which the following bureaus are established:

1. The Bureau of Facility Budgets.

2. The Bureau of Capital Expenditures.

3. The Bureau of Professional Fee Regulation.

(3) The commission shall have the authority to establish additional divisions and bureaus as necessary to properly implement the provisions of this act.

408.03 Qualifications of commissioners.—A commissioner may not, at the time of his appointment:

(1) Have any financial interest, other than ownership of shares in a mutual fund, in any business entity which, either directly or indirectly, owns or controls any entity regulated by the commission, in any entity regulated by the commission, or in any business entity which, either directly or indirectly, is an affiliate or subsidiary of any entity regulated by the commission.

(2) Be employed by, or engaged in, any business activity with any business entity which, either directly or indirectly, owns or controls any entity regulated by the commission, by any entity regulated by the commission, or by any business entity which, either directly or indirectly, is an affiliate or subsidiary of any entity regulated by the commission.

However, nothing in this section shall be construed to prohibit a health care practitioner, including a physician, from providing health care so long as he receives no income from his practice while employed as a commissioner.

408.04 Commissioners; standards of conduct.—

(1) STATEMENT OF INTENT.—In addition to the provisions of part III of chapter 112, which are applicable to health care commissioners by virtue of their being public officers and full-time employees of the executive branch of government, the conduct of health care commissioners shall be governed by the standards of conduct provided in this section. Nothing shall prohibit the standards of conduct from being more restrictive than the provisions of part III of chapter 112. Further, this section shall not be construed to contravene the restrictions of part III of chapter 112. In the event of a conflict between this section and part III of chapter 112, the more restrictive provision shall apply.

(2) STANDARDS OF CONDUCT.—

(a) A commissioner may not accept anything from any business entity which, either directly or indirectly, owns or controls any entity regulated by the commission, from any entity regulated by the commission, or from any business entity which, either directly or indirectly, is an affiliate or subsidiary of any entity regulated by the commission.

(b) A commissioner may not accept any form of employment with or engage in any business activity with any business entity which, either directly or indirectly, owns or controls any entity regulated by the commission, any entity regulated by the commission, or any business entity which, either directly or indirectly, is an affiliate or subsidiary of any health care facility regulated by the commission.

(c) A commissioner may not have any financial interest, other than shares in a mutual fund, in any entity regulated by the commission, in any business entity which, either directly or indirectly, owns or controls any entity regulated by the commission, or in any business entity which, either directly or indirectly, is an affiliate or subsidiary of any entity regulated by the commission. If a commissioner acquires any financial interest prohibited by this paragraph during his term of office as a result of events or actions beyond his control, he shall immediately sell such financial interest or place such financial interest in a blind trust at a financial institution. A commissioner may not attempt to influence, or exercise any control over, decisions regarding the blind trust.

(d) A commissioner may not accept anything from a party in a proceeding currently pending before the commission.

(e) A commissioner may not serve as the representative of any political party or on any executive committee or other governing body of a political party; serve as an executive officer or employee of any political party, committee, organization, or association; receive remuneration for activities on behalf of any candidate for public office; engage on behalf of any candidate for public office in the solicitation of votes or other activities on behalf of such candidacy; or become a candidate for election to any public office without first resigning from office.

(f) A commissioner, during his term of office, may not make any public comment regarding the merits of any proceeding under s. 120.57 currently pending before the commission.

(g) A commissioner may not conduct himself in an unprofessional manner at any time during the performance of his official duties.

However, nothing in this subsection shall be construed to prohibit a health care practitioner from providing health care so long as he receives no income from his practice while employed as a commissioner.

(3) The Commission on Ethics shall accept and investigate any alleged violations of this section pursuant to the procedures contained in ss. 112.322-112.3241. The Commission on Ethics shall provide the Governor with a report of its findings and recommendations. The Governor is authorized to enforce the findings and recommendations of the Commission on Ethics, pursuant to part III of chapter 112. A health care commissioner may request an advisory opinion from the Commission on Ethics, pursuant to s. 112.322(3)(a), regarding the standards of conduct or prohibitions set forth in this section and ss. 408.03 and 408.05.

408.05 Ex parte communications.—

(1) A commissioner shall accord to every person who is legally interested in a proceeding, or his attorney, full right to be heard according to law, and, except as authorized by law, shall neither initiate nor consider ex parte communications concerning the merits, threat, or offer of reward in any proceeding other than a proceeding under s. 120.54 or s. 120.565, workshops, or internal affairs meetings. No individual shall discuss ex parte with a commissioner the merits of any issue that he knows will be filed with the commission within 90 days. The provisions of this subsection shall not apply to commission staff.

(2) The provisions of this section shall not prohibit an individual from communicating with a commissioner, provided that the individual is representing only himself, without compensation.

(3) The provisions of this section shall not apply to oral communications or discussions in scheduled and noticed open public meetings of educational programs or of a conference or other meeting of an association of regulatory agencies.

(4) If a commissioner knowingly receives an ex parte communication relative to a proceeding other than as set forth in subsection (1), to which he is assigned, he shall place on the record of the proceeding copies of all written communications received, all written responses to the communications, and a memorandum stating the substance of all oral communications received and all oral responses made, and shall give written notice to all parties to the communication that such matters have been placed on the record. Any party who desires to respond to an ex parte communication may do so. The response must be received by the commission within 10 days after receiving notice that the ex parte communication has been placed on the record. The commissioner may, if he deems it necessary to eliminate the effect of an ex parte communication received by him, withdraw from the proceeding, in which case the chairman shall substitute another commissioner for the proceeding.

(5) Any individual who makes an ex parte communication shall submit to the commission a written statement describing the nature of such communication, to include the name of the person making the communication, the name of the commissioner or commissioners receiving the communication, copies of all written communications made, all written responses to such communications, and a memorandum stating the substance of all oral communications received and all oral responses made. The commission shall place on the record of a proceeding all such communications.

(6) Any commissioner who knowingly fails to place on the record any such communications, in violation of the section, within 15 days of the date of such communication is subject to removal and may be assessed a civil penalty not to exceed $5,000.

(7)(a) It shall be the duty of the Commission on Ethics to receive and investigate sworn complaints of violations of this section pursuant to the procedures contained in ss. 112.322-112.3241.

(b) If the Commission on Ethics finds that there has been a violation of this section by a health care commissioner, it shall provide the Governor with a report of its findings and recommendations. The Governor is authorized to enforce the findings and recommendations of the Commission on Ethics, pursuant to part III of chapter 112.

(c) If a commissioner fails or refuses to pay the Commission on Ethics any civil penalties assessed pursuant to the provisions of this section, the Commission on Ethics may bring an action in any circuit court to enforce such penalty.

408.06 Enforcement and interpretation.—Any violation of s. 408.05 by a commissioner, former commissioner, or former employee of the commission shall be punishable as provided in ss. 112.317 and 112.324. The Commission on Ethics is hereby given the power and authority to investigate complaints of violation of this chapter in the manner provided in part III of chapter 112, as if this section were included in that part. A commissioner may request an advisory opinion from the Commission on Ethics as provided by s. 112.322(3)(a).

408.07 Oath of office.—Before entering upon the duties of his office, each commissioner shall subscribe to the following oath: "I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am qualified to hold office under the State Constitution, and that I will well and faithfully perform at all times the duties of Health Care Commissioner, which I am now about to assume in a professional, independent, objective, and nonpartisan manner; that I do not have any financial, employment, or business interest which is prohibited by chapter 408, Florida Statutes; and that I will abide by the standards of conduct required of me by chapters 112 and 408, Florida Statutes, so help me God." In case any commissioner should in any way become disqualified, he shall at once remove such disqualification or resign, and upon his failure to do so, he shall be suspended from office by the Governor and dealt with as provided by law.

408.08 Place of meeting; expenditures; employment of personnel; records availability and fees.—

(1) The offices of the Health Care Commission shall be in the vicinity of Tallahassee, but the commissioners may hold meetings anywhere in the state at their discretion.

(2) All sums of money authorized to be paid on account of the commissioners shall be paid out of the State Treasury only on the order of the Comptroller.

(3) The commissioners may employ clerical, technical, and professional personnel reasonably necessary for the performance of their duties.

(4) Upon request by the governing body of a municipal or county government within 7 days after completion of the transcript and its delivery to the commission, the commission shall provide copies of the transcripts of testimony at the cost of reproduction and mailing, but such copies need not be certified unless specifically requested.

(5) The commission shall make available to the Public Counsel the original copy of all transcripts for use and study in the commission offices. If the commission makes any copies of transcripts for internal use and if the Public Counsel has so requested in writing to the clerk of the commission at the time of his intervention, the commission shall supply the Public Counsel with a copy of the transcript at no charge. In all other cases, the Public Counsel may obtain a copy of the transcript from the commission for the cost of reproduction.

(6) The commission shall collect for copying, examining, comparing, correcting, verifying, certifying, or furnishing orders, records, transcripts of testimony, papers, or other instruments the same fees that are allowed clerks of the circuit courts of Florida. In cases where the fee would amount to less than $1, no fee shall be charged.

(7) Copies of commission orders furnished to public officials, newspapers, periodical publications, federal agencies, state officials of other states, and parties to the proceeding in which the order was entered and their attorneys shall be without charge. However, the commission may in its discretion charge fees for the furnishing of more than one copy of any order to any of the foregoing parties.

(8) The commission shall keep a book in which all fees collected by it as provided for in this section shall be recorded, together with the amount and purpose for which they were collected. This book shall be a public record. The commission shall prepare a statement of these fees in duplicate each month and remit one copy of the statement, together with all fees collected by it, to the Treasurer. All moneys collected pursuant to this section by the commission shall be deposited in the State Treasury to the credit of the Health Care Trust Fund.

408.10 Former commissioners and employees; representation of clients before the commission.—

(1) Any former commissioner of the Health Care Commission is prohibited from appearing before the commission representing any client or any industry regulated by the Health Care Commission for a period of 2 years following termination of service on the commission.

(2) Any former employee of the commission is prohibited from appearing before the commission representing any client regulated by the Health Care Commission on any matter which was pending at the time of termination and in which such former employee had participated.

408.11 Public Counsel; appointment; oath; restrictions on Public Counsel and his employees.—

(1) The Public Counsel as established in s. 350.061 is hereby directed to represent the general public of Florida before the Health Care Commission.

(2) The powers and duties granted to the Public Council under s. 350.0611 are hereby granted to it with respect to the Health Care Commission. Furthermore, the Joint Legislative Auditing Committee shall have the authority described in ss. 350.0613 and 350.0614 with respect to the Health Care Commission.

408.12 Health Care Trust Fund; moneys to be deposited therein.—

(1) There is hereby created in the State Treasury a special fund to be designated as the Health Care Trust Fund which shall be used in the operation of the commission in the performance of the various functions and duties required of it by law.

(2) All fees, licenses, and other charges collected by the commission shall be deposited in the State Treasury to the credit of the Health Care Trust Fund, to be used in the operation of the commission as authorized by the Legislature. However, penalties and interest assessed and collected by the commission shall not be deposited in the trust fund but shall be deposited in the General Revenue Fund. The Health Care Trust Fund shall be subject to the service charge imposed pursuant to chapter 215.

(3) The commission shall maintain separate revenue accounts in the Health Care Trust Fund for every profession regulated by the commission. The commission shall, to the extent practicable, provide for the proportionate allocation among the accounts of expenses incurred by the commission in the performance of its duties with respect to each regulated profession. The commission shall provide each profession regulated by the commission with an annual report of revenue and allocated expenses related to the regulation of that profession, and these reports shall be used by the board to determine the amount of licensing fees for each profession regulated by the commission.

(4) All other moneys in the Health Care Trust Fund shall be for the use of the commission in the performance of its functions and duties as provided by law, subject to the fiscal and budgetary provisions of general law.

408.20 Commission inquiries; confidentiality of business material.—If the commission undertakes an inquiry, any records, documents, papers, maps, books, tapes, photographs, files, sound recordings, or other business material, regardless of form or characteristics, obtained by the commission incident to the inquiry are considered confidential and exempt from s. 119.07(1) while the inquiry is pending. If at the conclusion of an inquiry the commission undertakes a formal proceeding, any matter determined by the commission or by a judicial or administrative body, federal or state, to be trade secrets or proprietary confidential business information coming into its possession pursuant to such inquiry shall be considered confidential and exempt from s. 119.07(1). Such material may be used in any administrative or judicial proceeding so long as the confidential or proprietary nature of the material is maintained. The public records exemptions provided in this section are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

408.21 Oaths; depositions; protective orders.—The commission may administer oaths, take depositions, issue protective orders, issue subpoenas, and compel the attendance of witnesses and the production of books, papers, documents, and other evidence necessary for the purpose of any investigation or proceeding. Challenges to, and enforcement of, such subpoenas and orders shall be handled as provided in s. 120 58

408.22 Compelled testimony.—If any person called to testify in a commission proceeding shall refuse to testify because of a claim of possible self-incrimination, the commission, after consultation with the appropriate state attorney, may apply to the chief judge of the appropriate judicial circuit for a judicial grant of immunity ordering the testimony of such person notwithstanding his objection, but in such case no testimony or other information compelled under the order, or any information directly or indirectly derived from such testimony or other information, may be used against the witness in any criminal prosecution.

408.23 Administrative hearing officers.—Any provision of law to the contrary notwithstanding, the commission shall utilize hearing officers of the Division of Administrative Hearings of the Department of Administration to conduct hearings of the commission not assigned to members of the commission.

408.24 Penalties; rules; execution of contracts.—

(1) The commission may impose upon any entity regulated by the commission, that is found to have refused to comply with or willfully violated any lawful rule or order of the commission or any statute administered by the commission, a penalty for each such offense of not more than $5,000, to be fixed, imposed, and collected by the commission or the commission may, for any such violation, amend, suspend, or revoke any license or certificate issued by the commission. Each day that such refusal or violation continues shall constitute a separate offense. Each penalty shall be a lien upon the real and personal property of the entity, enforceable by the commission as a statutory lien under chapter 85. The net proceeds from the enforcement of any such lien shall be deposited in the General Revenue Fund.

(2) The commission is authorized to adopt, by affirmative vote of a majority of the commission, rules reasonably necessary to implement any law which it administers.

(3) The commission may designate one or more employees to execute contracts on behalf of the commission.

408.25 Judicial review.—

(1) The District Court of Appeal, First District, shall, upon petition, review any action of the commission.

(2) Notice of such review shall be given by the petitioner to all parties who entered appearances of record in the proceedings before the commission in which the order sought to be reviewed was made.

(3) Such parties may file briefs in support of their interests, as such interests may appear, within the time and in the manner provided by the Florida Rules of Appellate Procedure.

(4) Such parties shall be entitled as a matter of right to make oral argument in support of their interests, as such interests may appear, in any case in which oral argument is granted by the court on the application of the petitioner or the respondent.

408.26 Administrative rules.—

(1) By September 1, 1992, the Health Care Commission shall file for proposed adoption of the necessary rules for the implementation of this act. The rules shall provide, among other things, an administrative procedure pursuant to chapter 120. However, nothing contained in this act is intended to prohibit the commission from adopting in full the existing rules of the Health Care Cost Containment Board or the Department of Health and Rehabilitative Services, unless there is a direct conflict with provisions of this act.

(2) Nothing contained in this act is intended to repeal or modify any of the existing composition of the local health councils and the Statewide Health Council, or the state health plan or any of the local district health plans, unless there is a direct conflict with the provisions of this act.

408.27 Medical Advisory Panel.—There is created within the commission a Medical Advisory Panel. The panel shall serve in an advisory capacity to the commission. The panel shall be composed of eight members who shall be appointed by the chairman of the commission.

(1) The members of the panel shall include:

(a) Four physicians, licensed under chapter 458, chapter 459, chapter 460 and chapter 461, respectively, each of whom has been actively engaged in private practice in Florida for the past 5 years.

(b) The Vice President for Health Affairs of the University of Florida.

(c) The Deputy Secretary for Health of the Department of Health and Rehabilitative Services.

(d) An individual with expertise in health care data collection.

(e) A representative from a hospital licensed under chapter 395 who has expertise in utilization review.

(2) The members of the panel shall serve without compensation, but shall be reimbursed for per diem and travel expenses as provided in s. 112.061.

(3) The duties of the panel shall be to advise the commission in the performance of its duties and to formulate general policies affecting access to and cost of health care in the state. The duties of the panel shall include:

(a) Recommending to the commission minimum utilization review standards that should be used for the utilization review programs of all carriers and hospitals.

(b) Recommending to the commission those health care procedures, services, drugs, or devices which are experimental, investigational, outmoded, or not efficacious, or otherwise not sufficiently cost-effective to be included in basic health care services.

(c) Analyzing the health care data currently being collected and developing recommendations for improved data collection to assist in the private and public sector purchasing of health care services.

(d) Assisting in the development of practice parameters and recommending to the commission ways in which such parameters can be used to enhance utilization management programs and reduce the costs of defensive medicine. The panel and commission should encourage the use of nationally developed medical practice guidelines and outcomes research to measure and improve the quality of care and determine the appropriateness of medical procedures.

(e) Performing such functions as may assist the commission in its activities.

Section 28. *Health Care Work Group.—*

(1) CREATION; MEMBERSHIP.—There is hereby created the Health Care Work Group, hereinafter referred to as the "work group."

(a) Each of the following organizations shall appoint one member to the work group: the Academy of Florida Trial Lawyers; the Associated General Contractors Council; Associated Industries of Florida; the Association of Voluntary Hospitals of Florida; the Council of Statutory Teaching Hospitals; the Florida Association of Counties; the Florida Chamber of Commerce; the Florida Chapter of the American Federation of Labor-Congress of Industrial Organizations; the Florida Council of Seniors; the Florida Home Builders Association; the Florida League of Cities; the Florida League of Hospitals; the Florida Medical Association; the Florida Nurses Association; the Florida Pharmacy Association; the Association of Home Health Industries of Florida, Inc.; the Florida Chiropractic Association; the Florida Podiatric Medical Association; the Florida Hospital Association; Florida Hospices, Inc.; the Florida Retail Federation; Florida Society for Medical Technology; the Health Insurance Association of America; the National Federation of Independent Business; the Florida Physical Therapy Association; and the health insurer with the greatest health insurance premium volume in Florida. The President of the Florida Senate and the Speaker of the Florida House of Representatives shall each appoint one consumer representative to the work group.

(b) The members of the work group shall be appointed within 15 days after the effective date of this section. The work group shall hold its first meeting within 30 days after the effective date of this section and shall elect a chairperson from among its members.

(2) ADMINISTRATION; COMPENSATION.—

(a) The work group shall be located under the Legislature for administrative purposes. Staff assistance shall be provided by the Advisory Council on Intergovernmental Relations. The Health Care Cost Containment Board shall provide the work group with the services of an actuary and a certified public accountant. The board shall also provide any health-related data requested by the work group.

(b) Members of the work group shall not receive compensation for their service on the work group, and shall not be entitled to reimbursement for per diem or travel expenses.

(3) REPORT; RECOMMENDATIONS.—On or before January 1, 1992, the work group shall prepare and submit a report to the Governor, the Speaker of the House of Representatives, and the President of the Senate, which shall include the following:

(a) Recommendations for revisions to the goals, mandates, plans, and timeframes for the Health Care Commission, as specified in s. 408.01.

(b) Recommendations for draft rules or policy statements for use by the Health Care Commission in assuming its duties under the provisions of this act.

(c) Recommendations for any revisions to the legislation which established the Health Care Commission.

(4) EFFECTIVE DATE; REPEAL.—This section shall take effect upon becoming a law and shall stand repealed on April 1, 1992.

Section 29. *Effective April 1, 1992, section 407.01, Florida Statutes, as amended by chapters 88-394 and 90-295, Laws of Florida, and subsection (4) of section 407.04, Florida Statutes, as created by chapter 88-394, Laws of Florida, are hereby repealed.*

Section 30. *Effective April 1, 1992, sections 407.001, 407.003, 407.02 through 407.10, 407.13, 407.30, and 407.32 through 407.70, Florida Statutes, and sections 407.002, 407.11, 407.12, 407.23, and 407.31, Florida Statutes, 1990 Supplement, are renumbered as sections 408.501 through 408.90, respectively, and designated as part III of chapter 408, Florida Statutes.*

Section 31. *All powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Health Care Cost Containment Board are transferred by a type three transfer, as defined in s. 20.06(3), Florida Statutes, to the Health Care Commission, as created by this act. Such transfer shall take effect April 1, 1992. Any rules promulgated by or for the board are included in such transfer.*

Section 32. Effective April 1, 1992, the introductory paragraph of subsection (2) of section 624.215, Florida Statutes, is amended to read:

624.215 Proposals for legislation which mandates health benefit coverage; review by Legislature.—

(2) MANDATED HEALTH COVERAGE; REPORT TO *HEALTH CARE COMMISSION AND* LEGISLATIVE COMMITTEES; GUIDELINES FOR ASSESSING IMPACT.—Every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit to *the Health Care Commission and the* legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage. Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, shall include:

Section 33. *Except as otherwise specified in this act, in editing manuscript for the next edition of the official Florida Statutes, the Statutory Revision Division of the Joint Legislative Management Committee shall change "Department of Health and Rehabilitative Services" or "Secretary of Health and Rehabilitative Services" to "Health Care Commission," and "department," "secretary of the department," or "secretary" to "commission," wherever the terms appear in chapters 400 and 483, Florida Statutes, part II of section 408, Florida Statutes, as created by this act, and sections 381.0162, 395.002 through 395.008, 395.011, 395.0141, 395.0142, 395.0146, 395.02465(8) and (9), 395.015, 395.0175, 395.018, 395.0185, 395.031 through 395.037, 395.104, 407.002, 407.06, and 407.33, Florida Statutes, as consistent with the intent and purposes of this act.*

Section 34. *In editing manuscript for the next edition of the official Florida Statutes, the Statutory Revision Division of the Joint Legislative Management Committee shall change "Health Care Cost Containment Board" to "Health Care Commission," and "board" to "commission," wherever the terms appear in part III of chapter 408, Florida Statutes, as created by this act, and sections 112.153, 154.304, 381.703, 394.4787, 394.4788, 395.01465(6), 395.034, 395.101, 395.63, 400.609, 409.2673, 440.13, and 766.314, Florida Statutes, as consistent with the intent and purposes of this act.*

Section 35. *The Statutory Revision Division of the Joint Legislative Management Committee is hereby directed to prepare, with the assistance of the staffs of the appropriate substantive committees of the House of Representatives and the Senate, and in consultation with the Department of Health and Rehabilitative Services, appropriate legislation as needed to correct cross references and any other inconsistencies which may be found in the Florida Statutes as a result of the provisions of this act, in order to properly implement the legislative intent expressed herein, for submission to the 1992 Regular Session of the Legislature.*

Section 36. *Part I of chapter 408, Florida Statutes, is repealed on October 1, 1997, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.*

Section 37. *Section 408.27, Florida Statutes, is repealed on October 1, 1997, and the Medical Advisory Panel shall be reviewed by the Legislature pursuant to s. 11.611, Florida Statutes.*

Section 38. *Notwithstanding the provisions of the Regulatory Sunset Act or of any other provision of law which provides for review and repeal in accordance with s. 11.61, Florida Statutes, section 381.703, Florida Statutes, renumbered as section 408.303, Florida Statutes, by this act, shall not stand repealed on October 1, 1997, and part II of section 408, Florida Statutes, is repealed on October 1, 1994, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.*

Section 39. *Notwithstanding the provisions of the Regulatory Sunset Act or of any other provision of law which provides for review and repeal in accordance with s. 11.61, Florida Statutes, part I of chapter 395 and section 395.63, Florida Statutes, shall not stand repealed on October 1, 1992, and part I of chapter 395 and section 395.63, Florida Statutes, are repealed on October 1, 1993, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.*

Section 40. *Notwithstanding the provisions of the Regulatory Sunset Act or of any other provision of law which provides for review and repeal in accordance with s. 11.61, Florida Statutes, and except as otherwise specifically provided herein, chapter 407, Florida Statutes, redesignated as part III of chapter 408, Florida Statutes, by this act, shall not stand repealed on October 1, 1992, and part III of chapter 408, Florida Statutes, is repealed on October 1, 1993, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.*

Section 41. *Notwithstanding the provisions of the Regulatory Sunset Act or of any other provision of law which provides for review and repeal in accordance with s. 11.61, Florida Statutes, part VI of chapter 400, Florida Statutes, shall not stand repealed on October 1, 1995, and part VI of chapter 400, Florida Statutes, is repealed on October 1, 1993, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.*

Section 42. *Notwithstanding the provisions of the Regulatory Sunset Act or of any other provision of law which provides for review and repeal in accordance with s. 11.61, Florida Statutes, parts I and II of chapter 483, Florida Statutes, shall not stand repealed on October 1, 1993, and parts I, II, and III of chapter 483, Florida Statutes, are repealed on October 1, 1994, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.*

Section 43. *Effective March 1, 1992, there is hereby appropriated from the Health Care Cost Containment Trust Fund to the Health Care Commission the lump sum of $100,000 to provide for the startup expenses of the commission.*

Section 44. Except as otherwise provided herein, this part shall take effect April 1, 1992.

Part III
MEDICAID PROGRAM

Section 45. Section 409.901, Florida Statutes, is created to read:

409.901 Definitions.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(1) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under ss. 409.903-409.906 has been submitted to the department, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.

(2) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, goods, or services.

(3) "Claim" means any communication, whether oral, written, or electronic (electronic impulse or magnetic), which is used by any person to apply for payment from the Florida Medicaid Program or its fiscal agent for each item or service purported by any person to have been provided by a person to any Medicaid recipient.

(4) "Collateral" means:

(a) Any and all causes of action, suits, claims, counterclaims, and demands which accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care, goods, or services which necessitated that Medicaid provide medical assistance.

(b) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(c) Proceeds, as defined in this section.

(5) "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.

(6) "Department" means the Department of Health and Rehabilitative Services. The department is the Medicaid agency for the state, as provided under federal law.

(7) "Florida Medicaid Program" means the program authorized under Title XIX of the federal Social Security Act that provides for payments for medical items or services, or both, on behalf of any person who is determined by the department to be eligible on the date of service for Medicaid assistance.

(8) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.

(9) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in this state by the department.

(10) "Medicaid agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

(11) "Medicaid provider" or "provider" means a person or entity that has a Medicaid provider agreement in effect with the department and is in good standing with the department.

(12) "Medicaid provider agreement" or "provider agreement" means a contract between the department and a provider for the provision of services or goods, or both, to Medicaid recipients pursuant to Medicaid.

(13) "Medicaid recipient" or "recipient" means an individual whom the department determines is eligible, pursuant to federal and state law, to receive medical assistance and related services for which the department may make payments under the Florida Medicaid Program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Florida Medicaid Program, or an individual on whose behalf Medicaid has become obligated.

(14) "Medicaid-related records" means records that relate to the provider's business or profession and to a Medicaid recipient. Medicaid-related records include records related to non-Medicaid customers, clients, or patients but only to the extent that the documentation is shown by the department to be necessary to determine a provider's entitlement to payments under the Florida Medicaid Program.

(15) "Medical assistance" means any provision of, payment for, or liability for medical services by Medicaid to, or on behalf of, any recipient.

(16) "Medical services" or "medical care" means medical or medically related institutional or noninstitutional care, goods, or services covered by the Florida Medicaid Program. The term includes, without limitation, physician services, inpatient hospital services, outpatient hospital services, independent laboratory services, X-ray services, and prescribed drug services, and such other services as are covered by the Florida Medicaid Program.

(17) "Payment," as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. To "pay" means to do any of the acts set forth in this subsection.

(18) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "noncash proceeds."

(19) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.

(20) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the department, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance, or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 46. Section 409.902, Florida Statutes, is created to read:

409.902 Designated single state agency payment requirements; program title.—The Department of Health and Rehabilitative Services is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Florida Medicaid program."

Section 47. Section 409.903, Florida Statutes, is created to read:

409.903 Mandatory payments for eligible persons.—The department shall make payments for medical assistance and related services on behalf of the following persons who the department determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216.

(1) Persons who receive payments from or are determined eligible for the federal and state program known as Aid to Families with Dependent Children (AFDC), and certain persons who were eligible for that program but who became ineligible or who would be eligible but do not meet certain technical requirements. This group includes, but is not limited to:

(a) Low-income, single-parent families and their children.

(b) Low-income, two-parent families in which at least one parent is disabled or otherwise incapacitated.

(c) Certain unemployed two-parent families and their children.

(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI). This category includes a low-income person age 65 or over and a low-income person under age 65 considered to be permanently and totally disabled.

(3) A child under age 21 living in a low-income, two-parent family, and a child under age 7 living with a nonrelative, if the income and assets of the family or child, as applicable, do not exceed the cash-assistance limits under the Aid to Families with Dependent Children program.

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption.

(5) A pregnant woman for the duration of her pregnancy and for the post partum period as defined in federal law and rule or a child under age 1 if either is living in a family having an income that is less than 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

(6) A child born after September 30, 1983, living in a family that has an income which is less than 100 percent of the current federal poverty level, who has attained the age of 6, but has not attained the age of 19. In determining the eligibility of such a child, an assets test is not required.

(7) A child living in a family that has an income which is less than 133 percent of the current federal poverty level, who has attained the age of 1, but has not attained the age of 6. In determining the eligibility of such a child, an assets test is not required.

(8) A person who is age 65 or over or is determined by the department to be disabled, whose income is under 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the department. However, the department may only pay for premiums, coinsurance, and deductibles, as required by federal law, unless additional coverage is provided for any or all members of this group by section 409.904(1).

Section 48. Section 409.904, Florida Statutes, is created to read:

409.904 Optional payments for eligible persons.—The department may make payments for medical assistance and related services on behalf of the following persons who the department determines to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216.

(1) A person who is age 65 or older or is determined by the department to be disabled, whose income is under 100 percent of federal poverty level, and whose assets do not exceed limitations established by the department.

(2) A family, a pregnant woman, a child under age 18, a person age 65 or over, or a blind or disabled person who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed limitations established by the department. For a family or person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person in this group, which group is known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the mentally retarded.

(3) A person who is in need of the services of a licensed nursing facility, a licensed intermediate care facility for the mentally retarded, or a state mental hospital, whose income does not exceed 300 percent of the SSI income standard, and who meets the assets standards established under federal and state law.

(4) A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency medical services. The eligibility of such a recipient is limited to the period of the emergency, in accordance with federal regulations.

Section 49. Section 409.905, Florida Statutes, is created to read:

409.905 Mandatory Medicaid services.—The department may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the department to be eligible on the dates on which the services were provided. Any service under this section may be provided only when medically necessary, shall be provided in accordance with state and federal law, and is subject to the availability of moneys and any limitation established by the general appropriations act or chapter 216.

(1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The department shall pay for services provided to a recipient by a licensed advanced registered nurse practitioner who has a valid collaboration agreement with a licensed physician on file with the Department of Professional Regulation or who provides anesthesia services in accordance with established protocol required by state law and approved by the medical staff of the facility in which the anesthetic service is performed.

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The department shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the department to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

(3) FAMILY PLANNING SERVICES.—The department shall pay for services necessary to enable a recipient to plan voluntarily family size or to space children. These services include information, education, drugs and supplies, and necessary medical care and followup. Each recipient participating in the family planning portion of the Medicaid program must be provided freedom to choose any alternative method of family planning, as required by federal law.

(4) HOME HEALTH CARE SERVICES.—The department shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part III of chapter 400 or part II of chapter 499, if appropriate. These services, equipment, and supplies may be limited as provided in the general appropriations act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(5) HOSPITAL INPATIENT SERVICES.—The department shall pay for all services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395, except that payment for such care and treatment is limited to 45 days per state fiscal year per recipient, with the exception of a Medicaid recipient under age 21 in which case the only limitation is medical necessity. A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Medicaid program except as provided in federal law; however, the department shall apply for a waiver, within 3 months after the effective date of this part, designed to provide hospitalization services for mental health reasons to children and adults in the most cost effective and lowest cost setting possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMD's." The waiver proposal shall propose no additional aggregate cost to the state or federal government, and shall be conducted in District 6 of the Department of Health and Rehabilitative Services. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to ensure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers. The department is directed to monitor and evaluate the implementation of this waiver program if it is granted and report to the Chairs of the Appropriations Committees of the Senate and the House of Representatives by February 1, 1992.

(6) HOSPITAL OUTPATIENT SERVICES.—The department shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,000 per state fiscal year per recipient, unless an exception has been made by the department, and with the exception of a Medicaid recipient under age 21 in which case the only limitation is medical necessity.

(7) INDEPENDENT LABORATORY SERVICES.—The department shall pay for medically necessary diagnostic laboratory procedures ordered by a licensed physician or other licensed practitioner of the healing arts which are provided for a recipient in a laboratory that meets the requirements for Medicare participation and is licensed under chapter 483, if required.

(8) NURSING FACILITY SERVICES.—The department shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part I of chapter 400, which are ordered by and provided under the direction of a licensed physician.

(9) PHYSICIAN SERVICES.—The department shall pay for services and procedures rendered to a recipient by, or under the personal supervision of, a person licensed under state law to practice medicine or osteopathy. These services may be furnished in the physician's office, the Medicaid recipient's home, a hospital, a nursing facility, or elsewhere, but shall be medically necessary for the treatment of an injury, illness, or disease within the scope of the practice of medicine or osteopathy as defined by state law. The department shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

(10) PORTABLE X-RAY SERVICES.—The department shall pay for professional and technical portable radiological services ordered by a licensed physician or other licensed practitioner of the healing arts which are provided by a licensed professional in a setting other than a hospital, clinic, or office of a physician or practitioner of the healing arts, on behalf of a recipient.

(11) RURAL HEALTH CLINIC SERVICES.—The department shall pay for outpatient primary health care services for a recipient provided by a clinic certified by and participating in the Medicare program which is located in a federally designated, rural, medically underserved area and has on its staff one or more licensed primary care nurse practitioners or physician assistants, and a licensed staff supervising physician or a consulting supervising physician.

(12) TRANSPORTATION SERVICES.—The department shall ensure that transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for necessary and Medicaid-compensable services. The department may pay for transportation and other related travel expenses as necessary if these services are not otherwise available.

Section 50. Section 409.906, Florida Statutes, is created to read:

409.906 Optional Medicaid services.—The department may make payments for the following services, which are optional to the state under Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the department to be eligible on the dates on which the services were provided. Any service that is provided under this section may be provided only when medically necessary, must be provided in accordance with state and federal law, and is subject to any limitation established by the general appropriations act or chapter 216.

(1) ADULT DENTURE SERVICES.—The department may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older.

(2) ADULT HEALTH SCREENING SERVICES.—The department may pay for an annual routine physical examination, conducted by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(3) AMBULATORY SURGICAL CENTER SERVICES.—The department may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395, by or under the direction of a licensed physician or dentist.

(4) BIRTH CENTER SERVICES.—The department may pay for examinations and delivery, recovery, and newborn assessment, and related services, provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467, to a recipient expected to experience a low-risk pregnancy and delivery.

(5) CASE MANAGEMENT SERVICES.—The department may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, which services are rendered pursuant to federal guidelines.

(6) CHILDREN'S DENTAL SERVICES.—The department may pay for diagnostic, preventive, or corrective procedures, including orth-

odontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual.

(7) CHIROPRACTIC SERVICES.—The department may pay for manual manipulation of the spine and initial services, screening, and X rays provided to a recipient by a licensed chiropractic physician.

(8) COMMUNITY MENTAL HEALTH SERVICES.—The department may pay for rehabilitative services provided to a recipient in a mental health, drug abuse, or alcohol abuse center licensed by and under contract to the department which are psychiatric in nature and rendered or recommended by a psychiatrist or which are medical in nature and rendered or recommended by a physician or psychiatrist.

(9) DURABLE MEDICAL EQUIPMENT.—The department may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(10) HEARING SERVICES.—The department may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(11) HOME AND COMMUNITY-BASED SERVICES.—The department may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program.

(12) HOSPICE CARE SERVICES.—The department may pay for all reasonable and necessary services for the palliation or management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under the provisions of part V of chapter 400 and meets Medicare certification requirements.

(13) INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES.—The department may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed under chapter 393, to a recipient who needs such care because of his mental or physical condition.

(14) INTERMEDIATE CARE SERVICES.—The department may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part I of chapter 400, if the services are ordered by and provided under the direction of a physician.

(15) OPTOMETRIC SERVICES.—The department may pay for services provided to a recipient, including examination, diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.

(16) PODIATRIC SERVICES.—The department may pay for services, including diagnosis and medical, surgical, palliative, and mechanical treatment, related to ailments of the human foot and lower leg, if provided to a recipient by a podiatrist licensed under state law.

(17) PRESCRIBED DRUG SERVICES.—The department may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

(18) STATE HOSPITAL SERVICES.—The department may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state mental hospital.

(19) VISUAL SERVICES.—The department may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

Section 51. Section 409.907, Florida Statutes, is created to read:

409.907 Medicaid provider agreements.—The department may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with the department, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the department.

(1) Each provider agreement shall require the provider to comply fully with all state and federal laws pertaining to the Florida Medicaid program, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts, and shall require the provider to provide services or goods of not less than the scope and quality it provides to the general public.

(2) Each provider agreement shall be a voluntary contract between the department and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Florida Medicaid program when furnishing a service or goods to a Medicaid recipient and the department agrees to pay a sum, determined by fee schedule, payment methodology, or other manner, for the service or goods provided to the Medicaid recipient. Each provider agreement shall be effective for a stipulated period of time, shall be terminable by either party after reasonable notice, and shall be renewable by mutual agreement.

(3) The provider agreement developed by the department, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(a) Have in his possession at the time of signing the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional or facility license pertinent to the services or goods being provided, if required by the state or locality in which the provider is located, and the Federal Government, if applicable.

(b) Maintain in a systematic and orderly manner all medical and Medicaid-related records as the department may require and as it determines necessary for the services or goods being provided.

(c) Retain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the department.

(d) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

(e) Permit the department, the Auditor General, the Federal Government, and the authorized agents of each of these entities access to all Medicaid-related information, which may be in the form of records, logs, documents, computer files, and other information pertaining to services or goods billed to the Florida Medicaid program, including access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records.

(f) Bill other insurers and third parties, including the Medicare program, before billing the Florida Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person, and comply with all other state and federal requirements in this regard.

(g) Promptly report any moneys received in error or in excess of the amount to which the provider is entitled from the Florida Medicaid program, and promptly refund such moneys to the department.

(h) Be liable for and indemnify, defend, and hold the department harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient.

(i) At the option of the department, provide proof of liability insurance and maintain such insurance in effect for any period during which services or goods are furnished to Medicaid recipients.

(j) Accept Medicaid payment as payment in full, and prohibit the provider from billing or collecting from the recipient or the recipient's responsible party any additional amount except, and only to the extent the department permits or requires, copayments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided. The Medicaid payment-in-full policy does not apply to services or goods provided to a recipient if the services or goods are not covered by the Medicare program.

(4) A provider agreement shall provide that, if the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the department Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

(5) The department:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form shall require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the department, the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

(b) Is prohibited from demanding repayment from the provider in any instance in which the Medicaid overpayment is attributable to departmental error in the determination of eligibility of a recipient.

(c) May adopt, and include in the provider agreement, such other requirements and stipulations on either party as the department finds necessary to properly and efficiently administer the Florida Medicaid program.

(6) A Medicaid provider agreement may be revoked, at the option of the department, as the result of a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement. A provider shall give the department 60 days' notice before making any change in ownership of the entity named in the provider agreement as the provider.

(7) The department may require, as a condition of participating in the Florida Medicaid program and before entering into the provider agreement, that the provider submit information concerning the professional, business, and personal background of the provider. If the provider is a corporation, partnership, association, or other entity, the department may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater.

(8) Before signing a provider agreement, the department shall require the provider to submit:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state. The information required is that which pertains to the entity entering into the provider agreement with the department; to any principal, partner, or shareholder having an ownership interest in the entity of 5 percent or greater; and to any treating provider who participates or intends to participate in Medicaid through the entity acting as a group provider.

(c) Notice of and copies of court documents not sealed by the court of jurisdiction, related to any criminal charge brought in any court in the United States against the provider or the provider entity, or any principal, partner, or major shareholder thereof.

(d) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(e) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Florida Medicaid program.

(9) All statements and information furnished by the prospective provider for background information before signing the provider agreement shall be true and complete. The filing of materially incomplete or false information is sufficient cause for immediate termination of the provider from the Florida Medicaid program.

(10) Before signing a provider agreement and at the discretion of the department, other provisions of this section notwithstanding, an entity may become eligible to receive payment from the Medicaid program at the time it first furnishes services or goods if:

(a) The services or goods provided are otherwise compensable;

(b) The entity meets all other requirements of a Medicaid provider at the time the services or goods were provided; and

(c) The entity agrees to abide by the provisions of the provider agreement effective from the date the services or goods were provided.

(11) A provider may not reenroll in the Medicaid program once suspended or terminated if any fine or overpayment properly assessed has not been repaid, unless the department has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

(12) A provider who does not adhere to an agreed-upon repayment schedule, whether previously suspended or terminated, may be terminated by the department for nonpayment or partial payment.

Section 52. Section 409.908, Florida Statutes, is created to read:

409.908 Reimbursement of Medicaid providers.—The department shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the department and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, and other mechanisms the department considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations established by the general appropriations act or chapter 216.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited to 45 days per state fiscal year per recipient, except for children under age 21, in which case the only limitation is medical necessity or the payment amount. Reimbursement for hospital outpatient care is limited to $1,000 per state fiscal year per recipient, unless an exception has been made by the department, and with the exception of a Medicaid recipient under age 21 in which case the only limitation is medical necessity.

(b) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program, may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the general appropriations act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.9112, and 409.9113.

(2)(a) Reimbursement to nursing homes licensed under part I of chapter 400 and intermediate care facilities for the mentally retarded licensed under chapter 393 must be made prospectively. Reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment.

(b) The department shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care which utilizes a rate-setting mechanism whereby the rates are reasonable and adequate to cover a nursing home's cost which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards

and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. In the establishment of any maximum rate of payment, whether overall or component, the department shall base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(3) The following Medicaid services and goods shall be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the department, whichever amount is less, with the exception of those services or goods for which the department makes payment using a methodology based on average costs or negotiated fees.

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

(d) Community mental health services.

(e) Dental services, including oral and maxillofacial surgery.

(f) Durable medical equipment.

(g) Hearing services.

(h) Occupational therapy for Medicaid recipients under age 21.

(i) Optometric services.

(j) Orthodontic services.

(k) Personal care for Medicaid recipients under age 21.

(l) Physical therapy for Medicaid recipients under age 21.

(m) Podiatric services.

(n) Portable x-ray services.

(o) Private-duty nursing for Medicaid recipients under age 21.

(p) Respiratory therapy for Medicaid recipients under age 21.

(q) Speech therapy for Medicaid recipients under age 21.

(r) Visual services.

(4) Alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated by the department and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the department determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility.

(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the department. A provider of the visual, dental, and hearing components of such services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the department.

(7) A provider of family planning services shall be reimbursed the lesser of the amount billed by the provider or an all-inclusive amount per type of visit for physicians and advanced registered nurse practitioners as established by the department in a fee schedule.

(8) A provider of home-based or community-based services rendered pursuant to a federally approved waiver shall be reimbursed based on an established or negotiated rate for each service. These rates shall be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver program, or under any other methodology adopted by the department and approved by the Federal Government in accordance with the waiver.

(9) A provider of home health care services or of medical supplies and appliances shall be reimbursed the lesser of the amount billed by the provider or the department's established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the department's established maximum allowable amount whichever amount is less.

(10) A provider of hospice care services shall be reimbursed through a prospective-cost-reimbursement system for each Medicaid hospice provider.

(11) A provider of independent laboratory services shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the department.

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the department. Effective October 1, 1991, the department shall increase fees for surgical and other procedures for which fees have not been increased since 1987 to the median level of Medicare reimbursement in 1986 for Area B in this state.

(b) Reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which include prenatal, delivery, and postpartum care, shall be at least $1,500 per delivery for a pregnant woman with low medical risk and at least $2,000 per delivery for a pregnant woman with high medical risk, effective October 1, 1991. However, reimbursement to physicians working in Regional Perinatal Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made as specified in s. 409.266(7)(g). Nurse midwives licensed under chapter 464 and chapter 467 shall be paid at no less than 80 percent of the low medical risk fee. The department shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and shall not pay more based solely on the fact that a caesarean section was performed rather than a vaginal delivery. The department shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed.

(13) Premiums, deductibles, and coinsurance for Medicare services rendered to Medicaid eligible persons shall be reimbursed in accordance with fees established by Title XVIII of the Social Security Act.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the department, plus a dispensing fee.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver shall be reimbursed by payment of a fixed, prepaid monthly sum for each Medicaid recipient enrolled with the provider.

(16) A provider of rural health clinic services and federally qualified health center services shall be reimbursed a rate per visit based on total reasonable costs of the clinic.

(17) A provider of targeted case management services shall be reimbursed pursuant to an established fee, except where the Federal Government requires a public provider be reimbursed on the basis of average actual costs.

(18) A provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the department, except when the department has entered into a direct contract with the provider for the provision of an all-inclusive service, or when services are provided pursuant to an agreement negotiated between the department and the provider.

Section 53. Section 409.2665, Florida Statutes, 1990 Supplement, is transferred, renumbered as section 409.910, Florida Statutes, and amended to read:

409.910 ~~409.2665~~ Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(1) It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medi-

caid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien, and subrogation are to be abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources. It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.

(2) This section may be cited as the "Medicaid Third-Party Liability Act."

~~(3) As used in this section, the following words shall have the following meanings:~~

~~(a) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under s. 409.266 has been submitted to the department, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.~~

~~(b) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, good, or service.~~

~~(c) "Collateral" means:~~

~~1. Any and all causes of action, suits, claims, counterclaims, and demands which accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care which necessitated that Medicaid provide medical assistance.~~

~~2. All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.~~

~~3. Proceeds, as defined in this section.~~

~~(d) "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.~~

~~(e) "Department" means the Department of Health and Rehabilitative Services. The department is the Medicaid agency for the state, as provided under federal law.~~

~~(f) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.~~

~~(g) "Lienholder" means the department, which has a lien under paragraph (7)(c).~~

~~(h) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in Florida by the department.~~

~~(i) "Medicaid agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.~~

~~(j) "Medical assistance" means any provision of, payment for, or liability for medical services by Medicaid to, or on behalf of, any recipient.~~

~~(k) "Medical services" or "medical care" means medical or medically related institutional or noninstitutional care, goods, or services covered by the Florida Medicaid program. The term includes, without limitation, physician services, inpatient hospital services, outpatient hospital services, independent laboratory services, X-ray services, and prescribed drug services, and such other services as are covered by the Florida Medicaid program.~~

~~(l) "Payment," as it relates to third party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third party benefits for medical services. To "pay" means to do any of the acts set forth in this paragraph.~~

~~(m) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "noncash proceeds."~~

~~(n) "Provider" means any entity, including, without limitation, any hospital, physician, or other health care practitioner, supplier, or facility, providing medical care and related goods or services to a recipient.~~

~~(o) "Recipient" means any individual who has been determined to be eligible for Medicaid or who is receiving, or has received, medical assistance, or any medical care, good, or service for which Medicaid has paid or may be obligated.~~

~~(p) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.~~

~~(q) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the department, for any Medicaid-covered injury, illness, good, or service, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance, or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.~~

(3)~~(4)~~ Third-party benefits for medical services shall be primary to medical assistance provided by Medicaid.

(4)~~(5)~~ After the department has provided medical assistance under *the Florida Medicaid Program* ~~s. 409.266~~, it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the department has a waiver pursuant to federal law; or

(b) Situations in which the department learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid.

(5)~~(6)~~ An applicant, recipient, or legal representative shall inform the department of any rights the applicant or recipient has to third-party benefits and shall inform the department of the name and address of any person that is or may be liable to provide third-party benefits. When the department provides, pays for, or becomes liable for medical services provided by a hospital, the recipient receiving such medical services or his legal representative shall also provide the information as to third-party benefits, as defined in this section, to the hospital, which shall ~~periodically~~ provide notice thereof to the department in a manner specified by the department.

(6)~~(7)~~ When the department provides, pays for, or becomes liable for medical care under *the Florida Medicaid Program* ~~s. 409.266~~, it *has* ~~shall have~~ the following rights, as to which the department may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits:

(a) The department is automatically subrogated to any rights that an applicant, recipient, or legal representative has to any third-party benefit for the full amount of medical assistance provided by Medicaid. Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the department from any and all third-party benefits. Equities of a recipient, his legal representative, a recipient's creditors, or health care providers shall not defeat, reduce, or prorate recovery by the department as to its subrogation rights granted under this paragraph.

(b) By applying for or accepting medical assistance, an applicant, recipient, or legal representative automatically assigns to the department any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

1. The assignment granted under this paragraph is absolute, and vests legal and equitable title to any such right in the department, but not in excess of the amount of medical assistance provided by the department.

2. The department is a bona fide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person. Equities of a recipient, his legal representative, his creditors, or health care providers shall not defeat or reduce recovery by the department as to the assignment granted under this paragraph.

3. By accepting medical assistance, the recipient grants to the department the limited power of attorney to act in his name, place, and stead to perform specific acts with regard to third-party benefits, his assent being deemed to have been given, including:

a. Endorsing any draft, check, money order, or other negotiable instrument representing third-party benefits that are received on behalf of the recipient as a third-party benefit.

b. Compromising claims to the extent of the rights assigned, provided the recipient is not otherwise represented by an attorney as to the claim.

(c) The department is entitled to, and has, an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable, upon the collateral, as defined in *s. 409.901* ~~this section~~.

1. The lien attaches automatically when a recipient first receives treatment for which the department may be obligated to provide medical assistance under *the Florida Medicaid Program* ~~s. 409.266~~. The lien is perfected automatically at the time of attachment.

2. The department is authorized to file a verified claim of lien. The claim of lien shall be signed by an authorized employee of the *department* ~~lienholder~~, and shall be verified as to the employee's knowledge and belief. The claim of lien may be filed and recorded with the clerk of the circuit court in the recipient's last known county of residence or in any county deemed appropriate by the department. The claim of lien, to the extent known by the department, shall contain:

a. The name and last known address of the person to whom medical care was furnished.

b. The date of injury.

c. The period for which medical assistance was provided.

d. The amount of medical assistance provided or paid, or for which Medicaid is otherwise liable.

e. The names and addresses of all persons claimed by the recipient to be liable for the covered injuries or illness.

3. The filing of the claim of lien pursuant to this section shall be notice thereof to all persons.

4. If the claim of lien is filed within 1 year after the later of the date when the last item of medical care relative to a specific covered injury or illness was paid, or the date of discovery by the department of the liability of any third party, or the date of discovery of a cause of action against a third party brought by a recipient or his legal representative, record notice shall relate back to the time of attachment of the lien.

5. If the claim of lien is filed after 1 year *after* ~~of~~ the later of the events specified in subparagraph 4., notice shall be effective as of the date of filing.

6. Only one claim of lien need be filed to provide notice as set forth in this paragraph and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by Medicaid for any specific covered injury or illness. The department may, in its discretion, file additional, amended, or substitute claims of lien at any time after the initial filing, until the department has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

7. No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the *department* ~~lienholder~~ joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the *department is* ~~lienholder shall be~~ entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the *department* ~~lienholder~~ may recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid. Nothing in this section shall be construed as creating a lien or other obligation on the part of an insurer which in good faith has paid a claim pursuant to its contract without knowledge or actual notice that the department has provided medical assistance for the recipient related to a particular covered injury or illness. However, notice or knowledge that an insured is, or has been a Medicaid recipient within 1 year from the date of service for which a claim is being paid creates a duty to inquire on the part of the insurer as to any injury or illness for which the insurer intends *or is otherwise required* to pay benefits.

8. The lack of a properly filed claim of lien shall not affect the department's assignment or subrogation rights provided in this subsection, nor shall it affect the existence of the lien, but only the effective date of notice as provided in subparagraph 5.

9. The lien created by this paragraph is a first lien and superior to the liens and charges of any provider, and shall exist for a period of 7 years, if recorded, *after* ~~from~~ the date of recording; and shall exist for a period of 7 years *after* ~~from~~ the date of attachment, if not recorded. If recorded, the lien may be extended for one additional period of 7 years by rerecording the claim of lien within the 90-day period preceding the expiration of the lien.

10. The clerk of the circuit court for each county in the state shall endorse on a claim of lien filed under this paragraph the date and hour of filing and shall record the claim of lien in the official records of the county as for other records received for filing. The clerk shall receive as his fee for filing and recording any claim of lien or release of lien under this paragraph the total sum of $2. Any fee required to be paid by the department shall not be required to be paid in advance of filing and recording, but may be billed to the department after filing and recording of the claim of lien or release of lien.

11. After satisfaction of any lien recorded under this paragraph, the department shall, within *60* ~~30~~ days *after* ~~of~~ satisfaction, either file with the appropriate clerk of the circuit court or mail to any appropriate party, or counsel representing such party, if represented, a satisfaction of lien in a form acceptable for filing in Florida.

(7)~~(8)~~ The department shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

(a) Recovery of such benefits shall be collected directly from:

1. Any third party;

2. The recipient or legal representative, if he has received third-party benefits;

3. The provider of a recipient's medical services if third-party benefits have been recovered by the provider; notwithstanding any provision of this section, to the contrary, however, no provider shall be required to refund or pay to the department any amount in excess of the actual third-party benefits received by the provider from a third-party payor for medical services provided to the recipient; or

4. Any person who has received the third-party benefits.

(b) Upon receipt of any recovery or other collection pursuant to this section, the department shall distribute the amount collected as follows:

1. To itself, an amount equal to the state Medicaid expenditures for the recipient plus any incentive payment made in accordance with paragraph *(14)(a)*~~(15)(a)~~.

2. To the Federal Government, the federal share of the state Medicaid expenditures minus any incentive payment made in accordance with paragraph *(14)(a)*~~(15)(a)~~ and federal law, and minus any other amount permitted by federal law to be deducted.

3. To the recipient, after deducting any known amounts owed to the department for any related medical assistance or to health care providers, any remaining amount. This amount shall be treated as income or resources in determining eligibility for Medicaid.

(8)~~(9)~~ The department shall require an applicant or recipient, or the legal representative thereof, to cooperate in the recovery by the department of third-party benefits of a recipient and in establishing paternity and support of a recipient child born out of wedlock. As a minimal standard of cooperation, the recipient or person able to legally assign a recipient's rights shall:

(a) Appear at an office designated by the department to provide relevant information or evidence.

(b) Appear as a witness at a court or other proceeding.

(c) Provide information, or attest to lack of information, under penalty of perjury.

(d) Pay to the department any third-party benefit received.

(e) Take any additional steps to assist in establishing paternity or securing third-party benefits, or both.

(f) Paragraphs (a)-(e) notwithstanding, the department shall have the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

(9)~~(10)~~ The department shall deny or terminate eligibility for any applicant or recipient who refuses to cooperate as required in subsection *(8)*~~(9)~~, unless cooperation has been waived in writing by the department as provided in paragraph *(8)(f)*. ~~(9)(f); provided,~~ However, ~~that~~ any denial or termination of eligibility shall not reduce medical assistance otherwise payable by the department to a provider for medical care provided to a recipient prior to denial or termination of eligibility.

(10)~~(11)~~ An applicant or recipient shall be deemed to have provided to the department the authority to obtain and release medical information and other records with respect to such medical care, for the sole purpose of obtaining reimbursement for medical assistance provided by Medicaid.

(11)~~(12)~~ The department may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal *or administrative* proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(a) If either the recipient, or his legal representative, or the department brings an action against a third party, the recipient, or his legal representative, or the department, or their attorneys, shall, within 30 days *after* ~~of~~ filing the action, provide to the other written notice, by personal delivery or registered mail, of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If an action is brought by either the department, or the recipient or his legal representative, the other may, at any time before trial on the merits, become a party to, or shall consolidate his action with the other if brought independently. Unless waived by the other, the recipient, or his legal representative, or the department shall provide notice to the other of the intent to dismiss at least 21 days prior to voluntary dismissal of an action against a third party. Notice to the department shall be sent to an address set forth by rule. Notice to the recipient or his legal representative, if represented by an attorney, shall be sent to the attorney, and, if not represented, then to the last known address of the recipient or his legal representative.

(b) An action by the department to recover damages in tort under this subsection, which action is derivative of the rights of the recipient or his legal representative, shall not constitute a waiver of sovereign immunity pursuant to s. 768.14.

(c) In the event of judgment, award, or settlement in a claim or action against a third party, the court shall order the segregation of an amount sufficient to repay the department's expenditures for medical assistance, plus any other amounts permitted under this section, and shall order such amounts paid directly to the department.

(d) No judgment, award, or settlement in any action by a recipient or his legal representative to recover damages for injuries or other third-party benefits, when the department has an interest, shall be satisfied without first giving the department notice and a reasonable opportunity to file and satisfy its lien, and satisfy its assignment and subrogation rights or proceed with any action as permitted in this section.

(e) Except as otherwise provided in this section, notwithstanding any other provision of law, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the department's claims for reimbursement of the amount of medical assistance provided and any lien pursuant thereto.

(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his legal representative is a party and in which the amount of any judgment, award, or settlement from third-party benefits, excluding medical coverage as defined in subparagraph 4., after reasonable costs and expenses of litigation, is an amount equal to or less than 200 percent of the amount of medical assistance provided by Medicaid less any medical coverage paid or payable to the department, then distribution of the amount recovered shall be as follows:

1. Any fee for services of an attorney retained by the recipient or his legal representative shall not exceed an amount equal to 25 percent of the recovery, after reasonable costs and expenses of litigation, from the judgment, award, or settlement.

2. After attorney's fees, two-thirds of the remaining recovery shall be designated for past medical care and paid to the department for medical assistance provided by Medicaid.

3. The remaining amount from the recovery shall be paid to the recipient.

4. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

(g) In the event that the recipient, his legal representative, or his estate brings an action against a third party, notice of institution of legal proceedings, notice of settlement, and all other notices required by this section or by rule shall be given to the department, in Tallahassee, in a manner set forth by rule. All such notices shall be given by the attorney retained to assert the recipient's or legal representative's claim, or, if no attorney is retained, by the recipient, his legal representative, or his estate.

(h) Except as otherwise provided in this section, actions to enforce the rights of the department under this section shall be commenced within 5 years *after* ~~of~~ the date a cause of action accrues, with the period running from the later of the date of discovery by the department of a case filed by a recipient or his legal representative, or of discovery of any judgment, award, or settlement contemplated in this section, or of discovery of facts giving rise to a cause of action under this section. Nothing in this paragraph affects or prevents a proceeding to enforce a lien during the existence of the lien as set forth in subparagraph *(6)(c)9.* ~~(7)(c)9.~~

(i) Upon the death of a recipient, and within the time prescribed by ss. 733.702 and 733.710, the department, in addition to any other available remedy, may file a claim against the estate of the recipient for the total amount of medical assistance provided by Medicaid for the benefit of the recipient. Claims so filed shall take priority as class 3 claims as provided by s. 733.707(1)(c). The filing of a claim pursuant to this paragraph shall neither reduce nor diminish the general claims of the department pursuant to s. 409.345, except that the department shall not receive double recovery for the same expenditure. Claims under this paragraph shall be superior to those under s. 409.345. The death of the recipient shall neither extinguish nor diminish any right of the department to recover third-party benefits from a third party or provider. Nothing in this paragraph affects or prevents a proceeding to enforce a lien created pursuant to this section or a proceeding to set aside a fraudulent conveyance as defined in subsection *(16)*~~(17)~~.

(12)~~(13)~~ No action taken by the department shall operate to deny the recipient's recovery of that portion of benefits not assigned or subrogated to the department, or not secured by the department's lien. The department's rights of recovery created by this section, however, shall not be limited to some portion of recovery from a judgment, award, or settlement. Only the following benefits are not subject to the rights of the department: benefits not related in any way to a covered injury or illness; proceeds of life insurance coverage on the recipient; proceeds of insurance coverage, such as coverage for property damage, which by its terms and provisions cannot be construed to cover personal injury, death, or a covered injury or illness; proceeds of disability coverage for lost income; and recovery in excess of the amount of medical benefits provided by Medicaid after repayment in full to the department.

(13)~~(14)~~ No action of the recipient shall prejudice the rights of the department under this section. No settlement, agreement, consent decree, trust agreement, annuity contract, pledge, security arrangement, or any other device, hereafter collectively referred to in this subsection as a "settlement agreement," entered into or consented to by the recipient or his legal representative shall impair the department's rights. Provided, however, that in a structured settlement, no settlement agreement by the parties shall be effective or binding against the department for benefits accrued without the express written consent of the department or an appropriate order of a court having personal jurisdiction over the department.

(14)~~(15)~~ The department is authorized to enter into agreements to enforce or collect medical support and other third-party benefits.

(a) If a cooperative agreement is entered into with any agency, program, or subdivision of the state, or any agency, program, or legal entity of or operated by a subdivision of the state, or with any other state, the department is authorized to make an incentive payment of up to 15 percent of the amount actually collected and reimbursed to the department, to the extent of medical assistance paid by Medicaid. Such incentive payment is to be deducted from the federal share of that amount, to the extent authorized by federal law. The department may pay such person an additional percentage of the amount actually collected and reimbursed to the department as a result of the efforts of the person, but no more than a maximum percentage established by the department. In no case shall the percentage exceed the lesser of a percentage determined to be commercially reasonable or 15 percent, in addition to the 15-percent incentive payment, of the amount actually collected and reimbursed to the department as a result of the efforts of the person under contract.

(b) If an agreement to enforce or collect third-party benefits is entered into by the department with any person other than those described in paragraph (a), including any attorney retained by the department who is not an employee or agent of any person named in paragraph (a), then the department may pay such person a percentage of the amount actually collected and reimbursed to the department as a result of the efforts of the person, to the extent of medical assistance paid by Medicaid. In no case shall the percentage exceed a maximum established by the department, which shall not exceed the lesser of a percentage determined to be commercially reasonable or 30 percent of the amount actually collected and reimbursed to the department as a result of the efforts of the person under contract.

(c) An agreement pursuant to this subsection may permit reasonable litigation costs or expenses to be paid from the department's recovery to a person under contract with the department.

(d) Contingency fees and costs incurred in recovery pursuant to an agreement under this subsection may, for purposes of determining state and federal share, be deemed to be administrative expenses of the state. To the extent permitted by federal law, such administrative expenses shall be shared with, or fully paid by, the Federal Government.

(15)~~(16)~~ Insurance and other third-party benefits may not contain any term or provision which purports to limit or exclude payment or provisions of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance from Medicaid, and any such term or provision shall be void as against public policy.

(16)~~(17)~~ Any transfer or encumbrance of any right, title, or interest to which the department has a right pursuant to this section, with the intent, likelihood, or practical effect of defeating, hindering, or reducing recovery by the department for reimbursement of medical assistance provided by Medicaid, shall be deemed to be a fraudulent conveyance, and such transfer or encumbrance shall be void and of no effect against the claim of the department, unless the transfer was for adequate consideration and the proceeds of the transfer are reimbursed in full to the department, but not in excess of the amount of medical assistance provided by Medicaid.

(17)~~(18)~~ A recipient or his legal representative or any person representing, or acting as agent for, a recipient or his legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph *(6)(c)*~~(7)(c)~~, or who has actual knowledge of the department's rights to third-party benefits under this section, who receives any third-party benefit or proceeds therefrom for a covered illness or injury, is required either to pay the department the full amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid, or to place the full amount of the third-party benefits in a trust account for the benefit of the department pending judicial *or administrative* determination of the department's right thereto. Proof that any such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds therefrom were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that any such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed either to pay the department the full amount required by this section or to hold the full amount of third-party benefits or proceeds in trust pending judicial *or administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 409.325(4)(b), and acted with the intent set forth in s. 812.014(1).*

(a) In cases of suspected criminal violations or fraudulent activity, the department is authorized to take any civil action permitted at law or equity to recover the greatest possible amount, including, without limitation, treble damages under ss. 772.11 and 812.035(7).

(b) The department is authorized to investigate and to request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 409.325 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Auditor General, to the Attorney General, or to any state attorney. Pursuant to *s. 409.913* ~~s. 409.2664~~, the Auditor General has primary responsibility to investigate and control Medicaid fraud.

(c) In carrying out duties and responsibilities related to Medicaid fraud control, the department may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(d) All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft *is* ~~shall be~~ confidential and exempt from the provisions of s. 119.07(1):

1. Until such time as the department takes final agency action;

2. Until such time as the Auditor General refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

~~(19) Entities providing health insurance as defined in s. 624.603, shall, except as otherwise provided in this section, require that any check for third-party benefits be made payable to, and endorsed by, both the insured recipient, or his legal representative, and the provider, to ensure that the provider receives such third-party payment, and, if otherwise required by this section, that the department recovers from the provider. As provided in this section, the department may endorse any check on behalf of a recipient or legal representative as assignee of the recipient. Where the recovery from the insurer has been the subject of a judgment, award, or settlement, or when otherwise necessary to protect the department's rights under this section, the department shall recover directly from a health insurer, which shall require that any check for medical assistance be made payable to the department.~~

(18)~~(20)~~ In recovering any payments in accordance with this section, the department is authorized to make appropriate settlements.

(19)~~(21)~~ Notwithstanding any provision in this section to the contrary, the department shall not be required to seek reimbursement from a liable third party on claims for which the department determines that the amount it reasonably expects to recover will be less than the cost of recovery, or that recovery efforts will otherwise not be cost-effective.

(20)~~(22)~~ Entities providing health insurance as defined in s. 624.603, and health maintenance organizations and prepaid health clinics as defined in chapter 641, shall provide such records and information as are necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden.

(a) The secretary of the department and the Insurance Commissioner shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objective of this section.

1. The department shall request only that information necessary to determine whether health insurance as defined pursuant to s. 624.603, or those health services provided pursuant to chapter 641, could be, should be, or have been claimed and paid with respect to items of medical care and services furnished to any person eligible for services under this section.

2. All information obtained pursuant to subparagraph 1. *is* ~~shall be~~ confidential and exempt from ~~the provisions of~~ s. 119.07(1). This exemption *is* ~~shall be~~ subject to the Open Government Sunset Review Act in accordance with s. 119.14.

3. The cooperative agreement or rules *adopted* ~~promulgated~~ under this subsection may include financial arrangements to reimburse the reporting entities for reasonable costs or a portion thereof incurred in furnishing the requested information. Neither the cooperative agreement nor the rules shall require the automation of manual processes to provide the requested information.

(b) The department and the Department of Insurance jointly shall *adopt* ~~promulgate~~ rules for the development and administration of the cooperative agreement. The rules shall include the following:

1. A method for identifying those entities subject to furnishing information under the cooperative agreement.

2. A method for furnishing requested information.

3. Procedures for requesting exemption from the cooperative agreement based on an unreasonable burden to the reporting entity.

(21)~~(23)~~ The department is authorized to adopt rules to implement the provisions of this section and federal requirements.

Section 54. Section 409.911, Florida Statutes, is created to read:

409.911 Disproportionate share program.—The department shall distribute, pursuant to this section, moneys appropriated from the Public Medical Assistance Trust Fund to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) Definitions.—As used in this section and s. 409.9112:

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the Department of Health and Rehabilitative Services, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Actual audited data" or "actual audited experience" means data reported to the Department of Health and Rehabilitative Services which has been audited in accordance with generally accepted auditing standards by the department or representatives under contract with the department.

(c) "Base Medicaid per diem" means the hospital's Medicaid per diem rate initially established by the Department of Health and Rehabilitative Services on July 1 of each state fiscal year. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution.

(d) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Department of Health and Rehabilitative Services for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

(e) "Charity care days" means the sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

(f) "Disproportionate share percentage" means a rate of increase in the Medicaid per diem rate as calculated under this section.

(g) "Hospital" means a health care institution licensed as a hospital pursuant to chapter 395, but does not include ambulatory surgical centers.

(h) "Medicaid days" means the number of actual days attributable to Medicaid patients as determined by the Department of Health and Rehabilitative Services.

(2) The Department of Health and Rehabilitative Services shall utilize the following criteria to determine if a hospital qualifies for a disproportionate share payment:

(a) A hospital's total Medicaid days when combined with its total charity care days must equal or exceed 7 percent of its total adjusted patient days.

(b) A hospital's total charity care days weighted by a factor of 4.5 plus its total Medicaid days weighted by a factor of 1 shall be equal to or greater than 10 percent of its total adjusted patient days.

(c) Additionally, in accordance with the Seventh Federal Omnibus Budget Reconciliation Act, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

(3) In computing the disproportionate share rate:

(a) Per diem increases earned from disproportionate share shall be applied to each hospital's base Medicaid per diem rate and shall be capped at 100 percent.

(b) The department shall use the most recent calendar year audited data for the calculation of disproportionate share payments under this section.

(c) If the total amount earned by all hospitals under this section exceeds the amount appropriated, each hospital's share shall be reduced on a pro rata basis so that the total dollars distributed from the trust fund do not exceed the total amount appropriated.

(d) The total amount calculated to be distributed under this section shall be made in quarterly payments subsequent to each quarter during the fiscal year.

(4) Hospitals that qualify for a disproportionate share payment solely under paragraph (2)(c) shall have their payment calculated in accordance with the following formula:

$$TAA = TA \times (1/5.5)$$
$$DSHP = (HMD/TSMD) \times TAA$$

Where:

TAA = total amount available.

TA = total appropriation.

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSMD = total state Medicaid days.

(5) The following formula shall be utilized by the department to determine the maximum disproportionate share rate to be used to increase the Medicaid per diem rate for hospitals that qualify pursuant to paragraphs (2)(a) and (b):

$$DSR = \left(\left(\frac{CCD}{APD}\right) \times 4.5\right) + \left(\frac{MD}{APD}\right)$$

Where:

APD = adjusted patient days.

CCD = charity care days.

DSR = disproportionate share rate.

MD = Medicaid days.

(6) The following criteria shall be used in determining the disproportionate share percentage:

(a) If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.

(b) If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 2.1544347.

(c) If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 4.6415888766.

(d) If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 10.0000001388.

(e) If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 21.544347299

(f) If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 46.41588941.

(g) If the disproportionate share rate is greater than or equal to 60 percent, then the disproportionate share percentage is 100.

(7) The following formula shall be used by the department to calculate the total amount earned by all hospitals under this section:

$$TAE = BMPD \times MD \times DSP$$

Where:

TAE = total amount earned.

BMPD = base Medicaid per diem.

MD = Medicaid days.

DSP = disproportionate share percentage.

Section 55. Section 409.9112, Florida Statutes, is created to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.—In addition to the payments made under s. 409.911, the Department of Health and Rehabilitative Services shall design and implement a system of making disproportionate share payments to those hospitals that participate in the Regional Perinatal Intensive Care Center program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) The following formula shall be used by the department to calculate the total amount earned for hospitals that participate in the Regional Perinatal Intensive Care Center program.

$$TAE = DSR \times BMPD \times MD$$

Where:

TAE = Total Amount Earned by a Regional Perinatal Intensive Care Center.

DSR = Disproportionate Share Rate.

BMPD = Base Medicaid Per Diem.

MD = Medicaid Days.

(2) The total additional payment for hospitals that participate in the Regional Perinatal Intensive Care Center program shall be calculated by the department as follows:

$$TAP = \frac{TAE \times TA}{STAE}$$

Where:

TAP = Total Additional Payment for a Regional Perinatal Intensive Care Center.

TAE = Total Amount Earned by a Regional Perinatal Intensive Care Center.

STAE = Sum of Total Amount Earned by each hospital that participates in the Regional Perinatal Intensive Care Center program.

TA = Total Appropriation for the RPICC disproportionate share program.

(3) In order to receive payments under this section, a hospital must be participating in the Regional Perinatal Intensive Care Center program, pursuant to chapter 383, and must meet the following additional requirements:

(a) Agree to conform to all departmental requirements to ensure high quality in the provision of services, including criteria adopted by departmental rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department deems appropriate as specified by rule.

(b) Agree to provide information to the department, in a form and manner to be prescribed by rule of the department, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

(c) Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

(d) Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

(e) Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

(f) Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

(g) Agree to provide backup and referral services to the department's county public health units and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

(h) Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the department shall not receive any payments under this section until full compliance is achieved. A hospital which is not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating Regional Perinatal Intensive Care Center program hospitals.

Section 56. Section 409.9113, Florida Statutes, is created to read:

409.9113 Disproportionate share program for teaching hospitals.—In addition to the payments made under ss. 409.911 and 409.9112, the Department of Health and Rehabilitative Services shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) On or before September 15 of each year, the Health Care Cost Containment Board shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the department shall

distribute to each statutory teaching hospital, as defined in s. 407.002(27), an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index which comprises three components:

1. The Health Care Cost Containment Board Service Index, computed by applying the standard Service Inventory Scores established by the Health Care Cost Containment Board to services offered by the given hospital, as reported on the Health Care Cost Containment Board Worksheet A-2 for the last fiscal year reported to the board before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Health Care Cost Containment Board Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Health Care Cost Containment Board to the volume of each service, expressed in terms of the standard units of measure reported on the Health Care Cost Containment Board Worksheet A-2 for the last fiscal year reported to the board before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) The following formula shall be utilized by the department to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

(3) The Health Care Cost Containment Board shall report to the department the statutory teaching hospital allocation fraction prior to October 1 of each year.

Section 57. Section 409.9114, Florida Statutes, is created to read:

409.9114 Distribution of local government funds.—Subject to any limitations established within the General Appropriations Act, the department is authorized to receive on a monthly basis funds from local governments for the purpose of making payments, including federal matching funds, through the Medicaid expanded disproportionate share program.

(1) Payments made by the department to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(2) If the federal government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the department shall not distribute any additional funds and shall return all funds to the local governments from which the funds were received.

Section 58. Effective upon this act becoming a law, section 409.9115, Florida Statutes, is created to read:

409.9115 Extraordinary disproportionate share payments.—

(1) Subject to any limitations established within the General Appropriations Act or established pursuant to chapter 216, the department shall make a special extraordinary contribution to the care of indigent persons in this state. In order to be eligible to receive these funds, a hospital shall:

(a) Be qualified to participate in the disproportionate share program specified in section 409.917, popularly known as the "regular" disproportionate share program; and

(b) Have a ratio of net charity care expenditures to net operating expenditures that exceeds ten percent; and

(c) Be qualified to participate in the disproportionate share program specified in section 409.917(8), popularly known as the "RPICC" disproportionate share program; or

(d) Be a hospital having a licensed bed capacity of at least 600 beds operated by a special taxing district in a county having a population of at least one million persons.

(e) Be a statutory teaching hospital as defined in s. 407.002(27) with at least 35% of its inpatient days serving patients over 65 years of age.

(2) Payments made to an individual hospital from the total amount of funds to be disbursed under this program shall amount to the same percentage that each eligible hospital's regular disproportionate share payment comprises of the sum total of regular disproportionate share payments made to all hospitals eligible to participate in the extraordinary disproportionate share program.

(3) Each of the definitions and formulas specified in s. 409.911, shall be utilized, as applicable, for the purpose of computing the funds owed each hospital qualified under subsection (1) of this section, and paid in the appropriate percentage as specified in subsection (2).

(4) The department is authorized to receive funds from hospitals participating in the extraordinary disproportionate share program, and from local governments in whose jurisdiction a participating hospital resides, for the purpose of making payments, including federal matching funds, through the Medicaid extraordinary disproportionate share program. Funds received from hospitals or local governments for this purpose shall be separately accounted for, and shall not be co-mingled with other state or local funds in any manner.

(5) Payments made by the department to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(a) Should the federal government prohibit, restrict, or change in any manner the methods by which funds are distributed for this program, the department shall not distribute any additional funds, and shall return all funds to the entity from which the funds were received, except as provided in subsection (b).

(b) Should the federal government impose a restriction which still permits a partial or different distribution, the department may continue to disburse funds to hospitals participating in the extraordinary disproportionate share program in a federally approved manner, provided:

1. Each entity which contributes to the extraordinary disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each entity; and

2. The Executive Office of the Governor, Office of Planning and Budget, the House of Representatives and the Senate are provided at least seven days prior notice of the proposed change in the distribution, and do not disapprove such change.

(c) No distribution shall be made under the alternative method specified in subsection (b) unless all parties agree, or unless those parties who disagree have returned to them all funds not yet disbursed.

Section 59. Section 409.912, Florida Statutes, is created to read:

409.912 Cost-effective purchasing of health care.—The department shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The department shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies designed to facilitate the cost-effective purchase of a case-managed continuum of care. The department shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(1) The department may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and this act.

(2) The department may contract with health maintenance organizations certified pursuant to part II of chapter 641 for the provision of services to recipients.

(3) The department may contract with health units and other entities authorized by chapter 154 to provide health care services on a prepaid per capita or prepaid aggregate fixed-sum basis to recipients, which entities may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services are exempt from the provisions of part II of chapter 641.

(4) The department may contract with any public or private entity on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of health care services to recipients.

(a) An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

1. Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

2. Ensures that services meet the standards set by the department for quality, appropriateness, and timeliness;

3. Makes provisions satisfactory to the department for insolvency protection and ensures that neither enrolled Medicaid recipients nor the department will be liable for the debts of the entity;

4. Submits to the department, if a private entity, a financial plan that the department finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

5. Furnishes evidence satisfactory to the department of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

6. Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the department; and

7. Provides organizational, operational, financial, and other information required by the department.

(b) Entities that provide no prepaid health care services other than Medicaid services under contract with the department are exempt from the provisions of part II of chapter 641.

(5) The department may contract on a prepaid per capita or aggregate fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the department;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance.

(6) The department shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, or entered a plea of nolo contendere to:

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those proscribing price-fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(7) The department may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(8) The department shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(9) The department shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(10) The department shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

(11) The department shall identify health care utilization and price patterns within the Medicaid program that are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate.

(12) An entity contracting on a prepaid per capita or prepaid aggregate fixed sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the department or the Department of Insurance, by June 1, 1992, an

amount equal to its monthly prepaid Medicaid revenues; and by and after June 1, 1992, an amount equal to one-and-one-half times its monthly prepaid Medicaid revenues. In the event an entity's surplus falls below any applicable statutory requirements, or an entity's total of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the department or the Department of Insurance, falls below one-and-one-half times its monthly prepaid Medicaid revenues, the department shall prohibit the entity from engaging in enrollment activities, shall cease to process new enrollments for the entity, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection shall not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or

(b) Where the entity's performance and obligations are guaranteed in writing by a nonprofit guaranteeing organization which:

1. Has been in operation for at least 5 years and has assets in excess of $50 million; or

2. Submits a written guarantee acceptable to the department which is irrevocable during the term of the contracting entity's contract with the department and, upon termination of the contract, until the department receives proof of satisfaction of all outstanding obligations incurred under the contract.

Section 60. Section 409.913, Florida Statutes, is created to read:

409.913 Oversight of the integrity of the Medicaid program.—The department shall operate a program to oversee the activities of Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible.

(1) The department shall conduct, or cause to be conducted by contract or otherwise, investigations, analyses, and audits of possible fraud, abuse, and neglect in the Medicaid program and shall report the findings therefrom in departmental audit reports as appropriate.

(2) The department may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing, billing, and provision of care to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the department, without any suspicion or allegation of fraud, abuse, or neglect.

(3) Any suspected criminal violation or fraudulent activity by a provider, or by the representative or agent of a provider, identified by the department shall be referred to the Medicaid fraud control unit of the Office of the Auditor General for investigation.

(4) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer review organization designated by the department.

(5) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services which:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as may be authorized by the department.

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(6) A Medicaid provider shall retain professional and financial records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods.

(7) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect are confidential and exempt from the provisions of s. 119.07(1):

(a) Until the department takes final agency action respecting the provider and requires repayment of any overpayment, or imposes an administrative sanction;

(b) Until the Auditor General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if otherwise protected by law.

This exemption is subject to the Open Government Sunset Review Act in accordance with s 119 14.

(8) The department may impose administrative sanctions against a Medicaid provider if:

(a) The provider has entered into a pretrial intervention or other first-offender agreement respecting a charge of, has pled nolo contendere or guilty to a charge of, has been found guilty regardless of adjudication of, or has been convicted of Medicaid fraud or any other Medicaid-related crime, such as theft, bribery, giving or receiving a kickback, or neglecting or physically abusing a recipient;

(b) The provider has pled guilty to, has been found guilty regardless of adjudication of, or has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession;

(c) The provider is excluded from the Medicare program for cause;

(d) The provider's license has not been renewed, or has been revoked, suspended, or terminated, by the licensing agency of any state;

(e) The provider is excluded from participation in the Medicaid or Medicare program by the Federal Government or any state;

(f) The provider has refused access to Medicaid records to an authorized auditor or investigator acting as an employee or agent of the department, the Auditor General, a state attorney, or the Federal Government;

(g) The provider has not furnished, upon reasonable notice, such Medicaid-related records as the department found necessary to determine whether Medicaid payments are or were due and the amounts thereof;

(h) The provider is not in compliance with provisions of departmental policy manuals or handbooks which have been adopted by reference as rules in the Florida Administrative Code, state laws, federal rules and regulations, a provider agreement between the department and the provider, or certifications found on claim forms submitted by the provider or authorized representative as such provisions apply to the Medicaid program;

(i) The provider has furnished or ordered the furnishing to a recipient of goods or services that are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality. Such determinations must be based on competent peer judgments and evaluations;

(j) The provider or an authorized representative of the provider has knowingly submitted or caused to be submitted false or erroneous Medicaid claims that have resulted in payments to the provider in excess of those to which the provider was entitled under the Medicaid program;

(k) The provider or an authorized representative of the provider has knowingly submitted or caused to be submitted a Medicaid provider enrollment application, request for prior authorization for Medicaid services, or Medicaid cost report that contains materially false or incorrect information;

(l) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;

(m) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;

(n) The provider is indicted for fraudulent billing practices. The sanction applied for this reason is limited to suspension of the provider from the Medicaid program for the duration of the indictment;

(o) The provider is found liable for negligent practice resulting in death or injury to the provider's patient; or

(p) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Florida Medicaid program.

(9) The department may impose any of the following sanctions on a provider for any of the acts described in subsection (8):

(a) Suspension for a specific period of time of not more than 1 year.

(b) Termination for a specific period of time of from more than 1 year to 20 years.

(c) Imposition of a fine of up to $1,000 for each violation not exceeding a total fine of $25,000 in connection with any one audit or investigation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(10) In determining the appropriate administrative sanction to be applied, the department shall consider:

(a) The seriousness and extent of the violation or violations.

(b) Any prior history of violations by the provider.

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.

(d) Any pain and suffering inflicted by the provider on a recipient.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates.

(f) The extent to which a lesser sanction is sufficient to remedy the violation by the provider, in the best judgment of the department.

(g) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the department.

(11) The department may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group, if it determines such action is in the best interest of Medicaid recipients.

(12) In making a determination of overpayment to a provider, the department shall use appropriate and valid auditing, accounting, analytical, statistical, or peer review methods, or combinations thereof. Appropriate analytical methods include reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Florida Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period.

(13) When making a determination that an overpayment has occurred, the department shall prepare and issue a departmental audit report to the provider showing the calculation of overpayments.

(14) The departmental audit report, supported by department work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct or cross examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods or supplies; or inventory of drugs, goods or supplies, unless such acquisition, sales, divestment or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business.

(15)(a) In an investigation of a violation by a provider pursuant to this section, the department is entitled to recover investigative and expert costs not exceeding $25,000 if a material violation is found and the department's findings were not contested by the provider or, if contested, the department ultimately prevailed. However, should the provider contest the department's findings and prevail, he shall be entitled to recover investigative and expert witness costs.

(b) The department has the burden of documenting the investigative costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of investigative costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the investigative costs over a period to be determined by the department if the department determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of investigative costs may be collected by any means authorized by law for enforcement of a judgment.

(d) Investigative costs that are recovered must be returned to the department.

(16) If the department imposes an administrative sanction under this section for any of the acts described in subsection (8) upon any provider who is regulated by a state agency other than the department, the department shall notify that agency of the imposition of the sanction. Such notification must include the provider's name and license number and the specific reasons for sanction.

(17) The department may withhold Medicaid payments to a provider, up to the amount of the alleged overpayment, pending completion of an investigation under this section if it has reasonable cause to believe that the provider has committed one or more violations in relation to such payments. With the exception of providers terminated under the provisions of s. 120.59(3), in which case all payments shall be immediately terminated, the department may withhold payments under this provision, the monthly Medicaid payment may not be reduced by more than 10 percent, and the payments withheld must be paid to the provider within 60 days with interest at the rate of 10 percent a year upon determining that no such violation has occurred. If the amount of the alleged overpayment is in excess of $75,000, the department may reduce the Medicaid payments up to $25,000 per month.

Section 61. Section 409.914, Florida Statutes, is created to read:

409.914 Assistance for the uninsured.—The department shall use the claims payment systems, utilization control systems, cost control systems, case management systems, and other systems and controls that it has developed for the management and control of the Medicaid program to assist other agencies and entities, if appropriate, in paying claims and performing other activities necessary for the conduct of programs of state government, or for working with other public and private agencies to solve problems of lack of insurance, underinsurance, or uninsurability. When conducting these services, the department shall ensure:

(1) That full payment is received for services provided.

(2) That costs of providing these services are clearly segregated from costs necessary for the conduct of the Medicaid program.

(3) That the program conducted serves the interests of the state in ensuring that effective and quality health care at a reasonable cost is provided to the citizens of the state.

Section 62. Section 409.267, Florida Statutes, is renumbered as section 409.915, Florida Statutes, and amended to read:

(Substantial rewording of section. See s. 409.267, F.S., for present text.)

409.915 County contributions to Medicaid.—Although the state is responsible for the full portion of the state share of the matching funds required for the Florida Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(1) Each county shall participate in the following items of care and service:

(a) Payments for inpatient hospitalization in excess of 12 days, but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program.

(b) Payments for nursing home or intermediate facilities care in excess of $170 per month, with the exception of skilled nursing care for children under age 21.

(2) A county's participation must be 35 percent of the total cost of providing the items listed in subsection (1), except that the payments for items listed in paragraph (1)(b) may not exceed $55 per month per person.

(3) Each county shall set aside sufficient funds to pay for items of care and service provided to the county's eligible recipients for which county contributions are required, regardless of where in the state the care or service is rendered.

(4) Each county shall pay into the General Revenue Fund, unallocated, its pro rata share of the total county participation based upon statements rendered by the department in consultation with the counties.

(5) The Department of Banking and Finance shall withhold from the cigarette tax receipts or any other funds to be distributed to the counties the individual county share that has not been remitted within 60 days after billing.

(6) In any county in which a special taxing district or authority is located which will benefit from the medical assistance programs covered by this section, the board of county commissioners may divide the county's financial responsibility for this purpose proportionately, and each such district or authority must furnish its share to the board of county commissioners in time for the board to comply with the provisions of subsection (3). Any appeal of the proration made by the board of county commissioners must be made to the Department of Banking and Finance, which shall then set the proportionate share of each party.

Section 63. Section 409.916, Florida Statutes, is created to read:

409.916 Deposit of pharmaceutical rebates.—The department shall deposit any funds received from pharmaceutical manufacturers and all other funds received by the department from any other person as the result of a cost containment strategy, in the nature of a rebate, grant, or other similar mechanism into the General Revenue Fund.

Section 64. Section 409.2662, Florida Statutes, is renumbered as section 409.918, Florida Statutes, and amended to read:

409.918 ~~409.2662~~ Public Medical Assistance Trust Fund.—

~~(1)~~ It is declared that access to adequate health care is a right which should be available to all Floridians. However, rapidly increasing health care costs threaten to make such care unaffordable *for* ~~to~~ many citizens. The Legislature finds that unreimbursed health care services provided to persons who are unable to pay for such services cause the cost of services to paying patients to increase in a manner unrelated to the actual cost of services delivered. Further, the Legislature finds that inequities between hospitals in the provision of unreimbursed services prevent hospitals *that* ~~which~~ provide the bulk of such services from competing on an equitable economic basis with hospitals *that* ~~which~~ provide relatively little care to indigent persons. Therefore, it is the intent of the Legislature to provide a *method* ~~mechanism~~ for the funding *the provision* of health care services to indigent persons, the cost of which shall be borne by the state and by hospitals *that* ~~which~~ are granted the privilege of operating in this state.

(1)~~(2)~~ All moneys collected pursuant to s. 395.101 shall be deposited into the Public Medical Assistance Trust Fund, which is hereby created.

(2)~~(3)~~ There is hereby annually appropriated to the Public Medical Assistance Trust Fund $30 million from the General Revenue Fund.

(3)~~(4)~~ Moneys deposited into the Public Medical Assistance Trust Fund shall be used solely for the purposes *specified by law* ~~set out in s. 25, chapter 88-294, Laws of Florida, in s. 14, chapter 87-92, Laws of Florida, and in ss. 409.266(7), 409.2661, 409.2663, and 409.701 and as set forth in s. 3, chapter 89-355, Laws of Florida~~.

Section 65. Section 409.919, Florida Statutes, is created to read:

409.919 Rules.—The department shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements.

Section 66. Section 409.920, Florida Statutes, is created to read:

409.920 Medicaid provider fraud.—

(1) For the purposes of this section, the term:

(a) "Fiscal agent" means any individual, firm, corporation, partnership, organization, or other legal entity that has contracted with the department to receive, process, and adjudicate claims under the Florida Medicaid Program.

(b) "Item or service" includes:

1. Any particular item, device, medical supply, or service claimed to have been provided to a recipient and listed in an itemized claim for payment; or

2. In the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim.

(c) "Knowingly" means done by a person who is aware or should be aware of the nature of his conduct and that his conduct is substantially certain to cause the intended result.

(2) Any person who:

(a) Knowingly makes, causes to be made, or aids and abets in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the department or its fiscal agent for payment is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Knowingly makes, causes to be made, or aids and abets in the making of a claim for items or services that are not authorized to be reimbursed by the Florida Medicaid Program is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Knowingly charges, solicits, accepts, or receives anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Florida Medicaid Program or knowingly fails to credit the department or its fiscal agent for any payment received from a third-party source is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(d) Knowingly makes or in any way causes to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the department to determine a general or specific rate of payment for an item or service provided by a provider is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(e) Knowingly solicits, offers, pays, or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or

service for which payment may be made, in whole or in part, under the Florida Medicaid Program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Florida Medicaid Program is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(f) Knowingly fails to bill, or attempt to collect from a Medicaid recipient an authorized copayment for a Medicaid service that requires a copayment in return for specific Medicaid reimbursement is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(g) Knowingly submits false or misleading information or statements to the Florida Medicaid Program for the purpose of being accepted as a Medicaid provider is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) The repayment of Medicaid payments wrongfully obtained, or the offer or endeavor to repay Medicaid funds wrongfully obtained, does not constitute a defense to, or a ground for dismissal of, criminal charges brought under this section.

(4) All records in the custody of the department or its fiscal agent which relate to Medicaid provider fraud are business records within the meaning of s. 90.803(6).

(5) Proof that a claim was submitted to the department or its fiscal agent which contained a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to an inference that the person whose signature appears as the provider's authorizing signature on the claim form, or whose signature appears on a department electronic claim submission agreement submitted for claims made to the fiscal agent by electronic means, had knowledge of the false statement or false representation. This subsection applies whether the signature appears on the claim form or the electronic claim submission agreement by means of handwriting, typewriting, facsimile signature stamp, computer impulse, initials, or otherwise.

(6) Proof of submission to the department as its fiscal agent of a document containing items of income and expense used or that may be used by the department or its fiscal agent to determine a general or specific rate of payment and containing a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to the inference that the person who signed the certification of the document had knowledge of the false statement or representation. This subsection applies whether the signature appears on the document by means of handwriting, typewriting, facsimile signature stamp, electronic transmission, initials, or otherwise.

(7) Any person who agrees, conspires, combines, or confederates with another person to commit any act prohibited by subsection (2) is guilty of a misdemeanor of the first degree and is punishable as if he had actually committed such prohibited act. This subsection does not prohibit separate convictions and sentences for a violation of this subsection and a violation of any other provision of this section.

(8) A criminal action or proceeding under this section may be commenced at any time within 5 years after the cause of action accrues.

(9) The Auditor General shall conduct a statewide program of Medicaid fraud control. To accomplish this purpose, the Auditor General shall:

(a) Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Florida Medicaid Program, in the provision of medical assistance, or in the activities of providers of health care under the Florida Medicaid Program.

(b) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Florida Medicaid Program, in coordination with the department.

(c) Investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Florida Medicaid Program.

(d) Refer to the appropriate state attorney all violations indicating a substantial potential for criminal prosecution.

(e) Refer to the department all suspected abusive activities not of a criminal nature.

(f) Refer to the department for collection each instance of overpayment to a provider of health care under the Florida Medicaid Program which he discovers during the course of an investigation.

(g) Safeguard the privacy rights of all individuals and provide safeguards to prevent the use of patient medical records for any reason beyond the scope of a specific investigation for fraud or abuse, or both, without the patient's written consent.

(10) In carrying out his duties and responsibilities under this section, the Auditor General may:

(a) Enter upon the premises of any health care provider, excluding a physician, participating in the Florida Medicaid Program to examine all accounts and records that may, in any manner, be relevant in determining the existence of fraud in the Florida Medicaid Program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. A participating physician is required to make available any accounts or records that may, in any manner, be relevant in determining the existence of fraud in the Florida Medicaid Program. The accounts or records of a non-Medicaid patient may not be reviewed by, or turned over, to the Auditor General without the patient's written consent.

(b) Subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

Section 67. *There is hereby created within the Executive Office of the Governor the Task Force on County Contributions to Medicaid. The task force shall be composed of the following 11 members:*

(1)(a) The Secretary of Health and Rehabilitative Services or his designee.

(b) Four members to be appointed by the Governor.

(c) Five members to be appointed by the Florida Association of Counties, who shall each represent a different county.

(d) The Comptroller or his designee.

(2) The task force shall study the current method for county Medicaid billing, as required by s. 409.914, Florida Statutes, shall prepare recommendations regarding the adequacy of these current procedures, and shall propose any revisions necessary to facilitate prompt payment and to assist counties in budgeting for this expense. A report containing the findings and recommendations of the task force shall be submitted to the Speaker of the House of Representatives, the President of the Senate, and the Governor on or before February 1, 1992.

Section 68. *The Department of Health and Rehabilitative Services is directed to conduct a study of Florida's Medicaid reimbursement to pharmacy providers and prepare a report with recommendations on the adequacy of reimbursement for pharmaceutical ingredients and for the dispensing of prescriptions. The department shall, by December 15, 1991, submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.*

Section 69. Paragraph (d) of subsection (3) of section 110.123, Florida Statutes, 1990 Supplement, is amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(d)1. A person eligible to participate in the state group health insurance plan may be authorized by rules adopted by the Department of Administration, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The Department of Administration shall contract with health maintenance organizations to participate in the state group insurance program through a request for proposal based upon a premium and a minimum benefit package as follows:

a. The department shall establish a minimum benefit package to be provided by a participating HMO which shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO.

b. The department may establish a uniform schedule for deductibles and copayments for all participating HMOs.

c. Based upon the minimum benefit package and copayments and deductibles contained in sub-subparagraphs a. and b., the department shall issue a request for proposal for all HMOs which are interested in participating in the state group insurance program. Upon receipt of all proposals, the department may, as it deems appropriate, enter into contract negotiations with HMOs submitting bids. As part of the request for proposal process, the department may require detailed financial data from each HMO which participates in the bidding process for the purpose of determining the financial stability of the HMO.

d. In determining which HMOs to contract with, the department shall, at a minimum, consider: each proposed contractor's previous experience and expertise in providing prepaid health benefits; each proposed contractor's historical experience in enrolling and providing health care services to participants in the state group insurance program; the cost of the premiums; the plan's ability to adequately provide service coverage and administrative support services as determined by the department; plan benefits in addition to the minimum benefit package; accessibility to providers; and the financial solvency of the plan. Nothing shall preclude the department from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the department determines the plan has the best overall benefit package for the service areas involved. However, no HMO shall be eligible for a contract if the HMO's retiree Medicare premium exceeds the retiree rate as set by the department for the state group health insurance plan.

e. The department may limit the number of HMOs that it contracts with in each service area based on the nature of the bids it receives, the number of state employees in the service area, and any unique geographical characteristics of the service area. The department shall establish by rule service areas throughout the state.

f. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

3. The department is authorized to negotiate and contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The department may establish, subject to legislative approval pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums. A report shall be submitted to the Legislature by February 1, 1990, regarding establishment of any regional plan and its effect on the State Group Health Trust Fund.

4. In addition to contracting pursuant to subparagraph 2., the department shall enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under *the state Medicaid program* ~~s. 409.266~~;

b. Does not currently meet the 25 percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health and Human Services excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a. through d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal process described in subparagraph 2.

5. All enrollees in the state group health insurance plan or any health maintenance organization plan shall have the option of changing to any other health plan which is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year.

6. Any HMO participating in the state group insurance program shall, upon the request of the department, submit to the department standardized data for the purpose of comparison of the appropriateness, quality, and efficiency of care provided by the HMO. Such standardized data shall include: membership profiles; inpatient and outpatient utilization by age and sex, type of service, provider type, and facility; and emergency care experience. Requirements and timetables for submission of such standardized data and such other data as the department deems necessary to evaluate the performance of participating HMOs shall be promulgated by rule.

Section 70. Subsection (1) of section 154.011, Florida Statutes, is amended to read:

154.011 Primary care services.—

(1) It is the intent of the Legislature that all 67 counties offer primary care services through contracts, as required by s. 154.01(3), for Medicaid recipients and other qualified low-income persons. Therefore, beginning July 1, 1987, the Department of Health and Rehabilitative Services is directed, to the extent that funds are appropriated, to develop a plan to implement a program in cooperation with each county. The department shall coordinate with the county's primary care panel, as created by s. 154.013, or with the county's governing body if no primary care panel is appointed. Such primary care programs shall be phased-in and made operational as additional resources are appropriated ~~pursuant to s. 409.266(7)(c)~~, and shall be subject to the following:

(a) The department shall enter into contracts with the county governing body for the purpose of expanding primary care coverage. The county governing body shall have the option of organizing the primary care programs through county public health units or through county public hospitals owned and operated directly by the county. The department shall, as its first priority, maximize the number of counties participating in the primary care programs under this section, but shall establish priorities for funding based on need and the willingness of counties to participate. The department shall select counties for programs through a formal request-for-proposal process that requires compliance with program standards for cost-effective quality care and seeks to maximize access throughout the county.

(b) Each county's primary care program may utilize any or all of the following options of providing services: offering services directly through the county public health units; contracting with individual or group practitioners for all or part of the service; or developing service delivery models which are organized through the county public health units but which utilize other service or delivery systems available, such as federal primary care programs or prepaid health plans. In addition, counties shall have the option of pooling resources and joining with neighboring counties in order to fulfill the intent of this section.

(c) Each primary care program shall conform to the requirements and specifications of the department, and shall at a minimum:

1. Adopt a minimum eligibility standard of at least 100 percent of the federal nonfarm poverty level.

2. Provide a comprehensive mix of preventive and illness care services.

3. Be family oriented and be easily accessible regardless of income, physical status, or geographical location.

4. Ensure 24-hour telephone access and offer evening and weekend clinic services.

5. Offer continuity of care over time.

6. Make maximum use of existing providers and closely coordinate its services and funding with existing federal primary care programs, especially in rural counties, to ensure efficient use of resources.

7. Have a sliding fee schedule based on income for eligible persons above 100 percent of the federal nonfarm poverty level.

8. Include quality assurance provisions and procedures for evaluation.

9. Provide early periodic screening diagnostic and treatment services for Medicaid-eligible children.

10. Fully utilize and coordinate with rural hospitals for outpatient services, including contracting for services when advisable in terms of cost-effectiveness and feasibility.

Section 71. Subsection (7) of section 394 4787, Florida Statutes, 1990 Supplement, is amended to read:

394.4787 Definitions.—As used in this act:

(7) "PMATF" means the Public Medical Assistance Trust Fund ~~as created in s. 409.2662~~.

Section 72. Subsection (2) of section 395.01465, Florida Statutes, 1990 Supplement, is amended to read:

395.01465 Emergency care hospitals.—

(2) For the purpose of Medicaid swing-bed reimbursement pursuant to *the state Medicaid program* ~~s. 409.266(19)~~, the department shall treat emergency care hospitals in the same manner as hospitals defined in s. 395.102(2).

Section 73. Paragraph (b) of subsection (1) of section 400.126, Florida Statutes, is amended to read:

400.126 Receivership proceedings.—

(1) As an alternative to or in conjunction with an injunctive proceeding, the department may petition a court of competent jurisdiction for the appointment of a receiver, when any of the following conditions exist:

(b) The licensee is closing the facility or has informed the department that it intends to close the facility and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the facility. However, the failure on the part of the department, after receiving notice of the closing of a facility that is certified to provide services under Title XIX of the Social Security Act, a minimum of 90 days prior to the closing date, to make adequate arrangement for relocating those residents who are receiving assistance under *the state Medicaid program* ~~s. 409.266~~ shall in and of itself not be grounds to petition for the appointment of a receiver. Under these circumstances, if a facility remains open beyond the closing date, the department shall reimburse the facility for all costs incurred, up to the cap, for those residents who are receiving assistance under *the state Medicaid program* ~~s. 409.266~~, provided the facility continues to be licensed pursuant to this part and certified to provide services under Title XIX of the Social Security Act.

Section 74. Subsection (1) of section 400.18, Florida Statutes, is amended to read:

400.18 Closing of nursing facility.—

(1) Whenever a licensee voluntarily discontinues operation, and during the period when it is preparing for such discontinuance, it shall inform the department not less than 90 days prior to the discontinuance of operation. The licensee also shall inform the resident or the next of kin, legal representative, or agency acting on behalf of the resident of the fact, and the proposed time, of such discontinuance and give at least 90 days' notice so that suitable arrangements may be made for the transfer and care of the resident. In the event any resident has no such person to represent him, the licensee shall be responsible for securing a suitable transfer of the resident before the discontinuance of operation. The department shall be responsible for arranging for the transfer of those residents requiring transfer who are receiving assistance under *the state Medicaid program* ~~s. 409.266~~.

Section 75. Section 400.332, Florida Statutes, is amended to read:

400.332 Funds received not revenues for purpose of *state Medicaid* ~~medical assistance~~ program.—Any funds received by a nursing home in connection with its participation in the geriatric outpatient nurse clinic program shall not be considered as revenues for purposes of cost reports under the *state Medicaid* ~~medical assistance~~ program ~~as set forth in s. 409.266~~.

Section 76. Subsection (2) of section 407.51, Florida Statutes, is amended to read:

407.51 Exceeding approved budget or previous year's actual experience by more than maximum rate of increase; allowing or authorizing operating revenue or expenditures to exceed amount in approved budget; penalties.—

(2) Penalties shall be assessed as follows:

(a) For the first occurrence within a 5-year period, the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 5 percent; and, if such excess is greater than 5 percent over the maximum allowable rate of increase, any amount in excess of 5 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund~~, as created in s. 409.2662~~.

(b) For the second occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 2 percent; and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:

1. Levy a fine against the hospital in the total amount of the excess to be deposited in the Public Medical Assistance Trust Fund.

2. Notify the Department of Health and Rehabilitative Services of the violation, whereupon the department shall not accept any application for a certificate of need pursuant to ss. 381.701-381.7155 from or on behalf of such hospital until such time as the hospital has demonstrated to the satisfaction of the board that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected or amended budget or its applicable maximum allowable rate of increase for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.

3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the Department of Health and Rehabilitative Services, whereupon the department shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital *from the Public Medical Assistance Trust Fund* ~~pursuant to s. 409.266(7) or s. 409.2663~~. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital through the *Public Medical Assistance Trust Fund* ~~operation of s. 409.266(7) or s. 409.2663~~. It is the responsibility of the hospital to demonstrate to the satisfaction of the board its entitlement to such reduction. It is the intent of the Legislature that the Health Care Cost Containment Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix. For psychiatric hospitals, the board shall also reduce the amount of excess by utilizing as a proxy for case mix the change in a hospital's audited actual average length of stay as compared to the previous year's audited actual average length of stay without any thresholds or limitations.

Section 77. Paragraph (c) of subsection (6) of section 409.2673, Florida Statutes, 1990 Supplement, is amended to read:

409.2673 Shared county and state health care program for low-income persons; trust fund.—

(6)

(c) The state's portion of the funding shall be made available from the Public Medical Assistance Trust Fund~~, created under s. 409.2662, or from other funds appropriated by the Legislature~~.

Section 78. Subsection (10) of section 409.345, Florida Statutes, is amended to read:

409.345 Public assistance payments to constitute debt of recipient.—

(10) PUBLIC ASSISTANCE.—For the purposes of this section, the term "public assistance" *includes* ~~shall include~~ all money payments made to or on behalf of a recipient, including, but not limited to, assistance received under ss. 409.235 *and*~~,~~ 409.255, *the state Medicaid program,* ~~and 409.266~~ and mandatory and optional supplement payments under the Social Security Act.

Section 79. Paragraph (d) of subsection (5) of section 409.701, Florida Statutes, 1990 Supplement, is amended to read:

409.701 The Florida Small Business Health Access Corporation Act.—

(5) LICENSING, FISCAL OPERATION.—

(d) The corporation may expend funds through direct reinsurance, by purchasing reinsurance, or by other means approved by the board for the program of health care services and benefits arranged through the corporation. The amount of such expenditure shall not exceed funds allocated from the Public Medical Assistance Trust Fund ~~as provided in s. 409.2662(4)~~ or other sources of funding arranged by the corporation. Notwithstanding the provisions of s. 216.301, any amount so provided, which is not annually required for such purposes, shall remain available to the corporation, to be supplemented by an annual amount equal to the amount expended in the prior year, for the purpose of meeting funding requirements in succeeding years. Any amount remaining upon the liquidation or dissolution of the corporation shall be returned to the Public Medical Assistance Trust Fund.

Section 80. Section 410.036, Florida Statutes, is amended to read:

410.036 Eligibility for services.—Criteria for determining eligibility for this program shall be the same as criteria used to determine eligibility for assistance under Title XVI of the Social Security Act, as the same exists on July 1, 1977, or shall be the same as financial criteria used to determine eligibility for nursing home care under *the state Medicaid program* ~~s. 409.266~~.

Section 81. Paragraph (a) of subsection (9) of section 624.424, Florida Statutes, 1990 Supplement, is amended to read:

624.424 Annual statement and other information.—

(9)(a) Each authorized insurer shall, pursuant to *s. 409.910(21)* ~~s. 409.2665(22)~~, provide records and information to the Department of Health and Rehabilitative Services to identify potential insurance coverage for claims filed with that department and its fiscal agents for payment of medical services under *the state Medicaid program* ~~s. 409.266~~.

Section 82. Subsection (4) of section 627.736, Florida Statutes, 1990 Supplement, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority.—

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Department of Health and Rehabilitative Services provides, pays, or becomes liable for medical assistance under *the* Medicaid *program* ~~pursuant to chapter 409~~, related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of *the Medicaid program* ~~s. 409.2665~~.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. However, any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

(c) All overdue payments shall bear simple interest at the rate of 10 percent per year.

(d) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., provided the relative at the time of the accident is domiciled in the owner's household and is not himself the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle, provided the injured person is not himself:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner or owners of such a motor vehicle.

(e) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(f) Medical payments insurance, if available in a policy of motor vehicle insurance, shall pay the portion of any claim for personal injury protection medical benefits which is otherwise covered but is not payable due to the coinsurance provision of paragraph (1)(a), regardless of whether the full amount of personal injury protection coverage has been exhausted. The benefits shall not be payable for the amount of any deductible which has been selected.

Section 83. Section 631.813, Florida Statutes, is amended to read:

631.813 Application of part.—This part shall apply to HMO contractual obligations to residents of Florida by HMOs possessing a valid certificate of authority issued by the Florida Department of Insurance as provided by part II of chapter 641. The provisions of this part shall not apply to persons participating in medical assistance programs *under the state Medicaid program* ~~created pursuant to s. 409.266~~.

Section 84. Subsection (1) of section 641.261, Florida Statutes, 1990 Supplement, is amended to read:

641.261 Other reporting requirements.—

(1) Each authorized health maintenance organization shall provide records and information to the Department of Health and Rehabilitative Services pursuant to *s. 409.910(21)* ~~s. 409.2665(22)~~ for the sole purpose of identifying potential coverage for claims filed with the Department of Health and Rehabilitative Services and its fiscal agents for payment of medical services under *the state Medicaid program* ~~s. 409.266~~.

Section 85. Subsection (14) of section 641.31, Florida Statutes, 1990 Supplement, is amended to read:

641.31 Health maintenance contracts.—

(14) Whenever a subscriber of a health maintenance organization is also a Medicaid recipient, the health maintenance organization's coverage shall be primary to the recipient's Medicaid benefits and the organization shall be a third party subject to the provisions of *s. 409.910(4)* ~~s. 409.2665~~.

Section 86. Subsection (1) of section 641.411, Florida Statutes, 1990 Supplement, is amended to read:

641.411 Other reporting requirements.—

(1) Each prepaid health clinic shall provide records and information to the Department of Health and Rehabilitative Services pursuant to *s. 409.910(21)* ~~s. 409.2665(22)~~ for the sole purpose of identifying potential coverage for claims filed with the Department of Health and Rehabilitative Services and its fiscal agents for payment of medical services under *the state Medicaid program* ~~s. 409.266~~.

Section 87. Paragraph (b) of subsection (2) of section 768.73, Florida Statutes, is amended to read:

768.73 Punitive damages; limitation.—

(2) In any civil action, an award of punitive damages shall be payable as follows:

(b) If the cause of action was based on personal injury or wrongful death, 60 percent of the award shall be payable to the Public Medical Assistance Trust Fund ~~created in s. 409.2672~~; otherwise, 60 percent of the award shall be payable to the General Revenue Fund.

Section 88. Subsection (1) of section 895.02, Florida Statutes, 1990 Supplement, is amended to read:

895.02 Definitions.—As used in ss. 895.01-895.08, the term:

(1) "Racketeering activity" means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce, or intimidate another person to commit:

(a) Any crime which is chargeable by indictment or information under the following provisions of the Florida Statutes:

1. Section 210.18, relating to evasion of payment of cigarette taxes.

2. Section 403.727(3)(b), relating to environmental control.

3. Section 409.325, relating to public assistance fraud.

4. Section 409.920, relating to Medicaid provider fraud.

5. ~~4.~~ Chapter 517, relating to sale of securities and investor protection.

6. ~~5.~~ Section 550.24, s. 550.35, or s. 550.36, relating to dogracing, horseracing, and jai alai frontons.

7. ~~6.~~ Section 551.09, relating to jai alai frontons.

8. ~~7.~~ Chapter 552, relating to the manufacture, distribution, and use of explosives.

9. ~~8.~~ Chapter 562, relating to beverage law enforcement.

10. ~~9.~~ Section 655.50, relating to reports of currency transactions, when such violation is punishable as a felony.

11. ~~10.~~ Chapter 687, relating to interest and usurious practices.

12. ~~11.~~ Section 721.08, s. 721.09, or s. 721.13, relating to real estate time-share plans.

13. ~~12.~~ Chapter 782, relating to homicide.

14. ~~13.~~ Chapter 784, relating to assault and battery.

15. ~~14.~~ Chapter 787, relating to kidnapping.

16. ~~15.~~ Chapter 790, relating to weapons and firearms.

17. ~~16.~~ Section 796.01, s. 796.03, s. 796.04, s. 796.05, or s. 796.07, relating to prostitution.

18. ~~17.~~ Chapter 806, relating to arson.

19. ~~18.~~ Chapter 812, relating to theft, robbery, and related crimes.

20. ~~19.~~ Chapter 815, relating to computer-related crimes.

21. ~~20.~~ Chapter 817, relating to fraudulent practices, false pretenses, fraud generally, and credit card crimes.

22. ~~21.~~ Section 827.071, relating to commercial sexual exploitation of children.

23. ~~22.~~ Chapter 831, relating to forgery and counterfeiting.

24. ~~23.~~ Chapter 832, relating to issuance of worthless checks and drafts.

25. ~~24.~~ Section 836.05, relating to extortion.

26. ~~25.~~ Chapter 837, relating to perjury.

27. ~~26.~~ Chapter 838, relating to bribery and misuse of public office.

28. ~~27.~~ Chapter 843, relating to obstruction of justice.

29. ~~28.~~ Section 847.011, s. 847.012, s. 847.013, s. 847.06, or s. 847.07, relating to obscene literature and profanity.

30. ~~29.~~ Section 849.09, s. 849.14, s. 849.15, s. 849.23, or s. 849.25, relating to gambling.

31. ~~30.~~ Chapter 893, relating to drug abuse prevention and control.

32. ~~31.~~ Chapter 896, relating to offenses related to financial transactions.

33. ~~32.~~ Sections 914.22 and 914.23, relating to tampering with a witness, victim, or informant, and retaliation against a witness, victim, or informant.

34. ~~33.~~ Sections 918.12 and 918.13, relating to tampering with jurors and evidence.

(b) Any conduct defined as "racketeering activity" under 18 U.S.C. s. 1961(1).

Section 89. *Any diagnosis-specific supplemental funding to nursing homes shall not operate to prevent or create a disincentive for an otherwise terminally ill individual residing in a nursing home from electing the Medicare or Medicaid hospice benefits.*

Section 90. *Rules adopted by the Department of Health and Rehabilitative Services prior to October 1, 1991, under the authority of any statutory provision amended or repealed by this act shall remain in effect and shall be administered by the department until the department adopts rules that supersede those rules.*

Section 91. *Section 21 of chapter 89-275, Laws of Florida; subsection (3) of section 400.23, Florida Statutes, as amended by section 1 of chapter 90-125, Laws of Florida; section 409.266, Florida Statutes, as amended by section 5 of chapter 90-232, Laws of Florida, section 10 of chapter 90-284, Laws of Florida, sections 17 and 34 of chapter 90-295, Laws of Florida, and section 6 of chapter 90-341, Laws of Florida; and sections 409.2662, 409.2663, 409.2664, 409.267, 409.2671, and 409.268, Florida Statutes, are repealed.*

Section 92. Except as otherwise provided herein, this part shall take effect October 1, 1991.

Part IV
HEALTHY START

Section 93. *(1) The Legislature recognizes the importance of providing early prenatal care as a primary means to ensure healthy births. The Legislature also recognizes that one of the most effective weapons in the fight against infant mortality is early, high quality, and comprehensive prenatal care. Despite this convincing evidence that prenatal care is effective in improving pregnancy outcomes, access to prenatal care for all pregnant women has not been achieved in this state. Therefore, it is the intent of the Legislature to assure that the existing eco-*

nomic, social, and geographic barriers to health care are minimized, and that an adequate number of health care providers remain available to assist pregnant women and their infants.

(2) Therefore, it is the overall intent of the Legislature to promote and protect the health and well being of all pregnant women and their children through the provision and accessibility of health care programs to fully meet the health requirements of this population.

(3) The Legislature recognizes the importance of community-based coalitions that combine the resources and talents of its citizenry with involvement of its local business communities. The Legislature also believes that information derived through community involvement is a vital contribution to the success of any state initiative, and is desirous to use this information where available and accessible. Therefore, it is the intent of the Legislature to provide assistance in the establishment of such coalitions in order to ensure that the voice of Florida's communities be heard through the creation of prenatal and infant health care coalitions.

Section 94. Effective March 1, 1992, section 383.14, Florida Statutes, 1990 Supplement, is amended to read:

383.14 Screening ~~of infants~~ for metabolic *disorders,* ~~and~~ other hereditary and congenital disorders, *and environmental risk factors.*—

(1) SCREENING REQUIREMENTS.—To help ensure access to the maternal and child health care system, ~~It shall be the duty of~~ the Department of Health and Rehabilitative Services *shall* ~~to~~ promote the screening of all infants born in Florida for phenylketonuria and other metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. *The department shall also promote the identification and screening of all infants born in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and intervention efforts shall begin prior to and immediately following the birth of the child by the attending health care provider. Such efforts shall be conducted in hospitals, perinatal centers, county public health units, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.*

(a) Prenatal screening.—The department shall develop a multilevel screening process that includes a risk-assessment instrument to identify women at risk for a preterm birth or other high-risk condition. The primary health care provider shall complete the risk-assessment instrument and report the results to the Office of Vital Statistics so that the woman may immediately be notified and referred to appropriate health, education, and social services.

(b) Postnatal screening.—A risk-factor analysis using the department's designated risk-assessment instrument shall also be conducted as part of the medical screening process upon the birth of a child and submitted to the department's Office of Vital Statistics for recording and other purposes provided for in this chapter. The department's screening process for risk assessment shall include a scoring mechanism and procedures that establish thresholds for notification, further assessment, referral, and eligibility for services by professionals or paraprofessionals consistent with the level of risk. Procedures for developing and using the screening instrument, notification, referral, and care coordination services, reporting requirements, management information, and maintenance of a computer-driven registry in the Office of Vital Statistics which ensures privacy safeguards must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter. Procedures established for reporting information and maintaining a confidential registry must include a mechanism for a centralized information depository at the state and county levels. The department shall coordinate with existing risk-assessment systems and information registries. The department must ensure, to the maximum extent possible, that the screening information registry is integrated with the department's automated data systems, including the Florida On-line Recipient Integrated Data Access (FLORIDA) system. Tests *and screenings must* ~~shall~~ be performed at such times and in such manner as *is* ~~may be~~ prescribed by the department after consultation with the Genetics and Infant Screening Advisory Council *and the State Coordinating Council for Early Childhood Services.*

(2)~~(1)~~ RULES.—After consultation with the Genetics and Infant Screening Advisory Council, the department shall *adopt* ~~promulgate~~ and enforce rules requiring that every infant born in *this state* ~~Florida~~ shall, prior to becoming 2 weeks of age, be subjected to a test for phenylketonuria and, at the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary from time to time. *After consultation with the State Coordinating Council for Early Childhood Services, the department shall also adopt and enforce rules requiring every infant born in this state to be screened for environmental risk factors that place children and their families at risk for increased morbidity, mortality, and other negative outcomes.* The department is empowered to promulgate such additional rules as are found necessary for the administration of this section, including rules relating to the methods used and time or times for testing as accepted medical practice indicates, and rules requiring mandatory reporting of the results of tests *and screenings* for these conditions to the department.

(3)~~(2)~~ DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES; POWERS AND DUTIES.—The department shall administer and provide certain services to implement the provisions of this section and shall:

(a) Assure the availability and quality of the necessary laboratory tests and materials.

(b) Furnish all physicians, *county* public health units, *perinatal centers, birthing centers,* and hospitals forms on which *environmental screening and* the results of tests for phenylketonuria and such other disorders for which testing may be required from time to time shall be reported to the department.

(c) Promote education of the public about the prevention and management of metabolic, hereditary, and congenital disorders *and dangers associated with environmental risk factors.*

(d) Maintain a confidential registry of cases, including information of importance for the purpose of followup services to prevent mental retardation, to correct or ameliorate physical handicaps, and for epidemiologic studies, if indicated. Such registry shall be exempt from the provisions of s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(e) Supply the necessary dietary treatment products where practicable for diagnosed cases *of phenylketonuria and other metabolic diseases* for as long as medically indicated when the products are not otherwise available. *Provide nutrition education and supplemental foods to those families eligible for the Special Supplemental Food Program for Women, Infants, and Children as provided in s. 383.011.*

(f) Promote the availability of genetic studies and counseling in order that the parents, siblings, and affected infants may benefit from available knowledge of the condition.

All provisions of this subsection shall be coordinated with the provisions and plans established under this chapter, chapter 411, and Pub. L. No. 99-457.

(4)~~(3)~~ OBJECTIONS OF PARENT OR GUARDIAN.—The provisions of this section shall not apply when the parent or guardian of the child objects thereto. A written statement of such objection shall be presented to the physician or other person whose duty it is to administer and report ~~such~~ tests *and screenings* under ~~the provisions of~~ this section.

(5)~~(4)~~ ADVISORY COUNCIL.—There is established a Genetics and Infant Screening Advisory Council made up of 12 members appointed by the Secretary of Health and Rehabilitative Services. The council shall be composed of two consumer members, three practicing pediatricians, at least one of whom must be a pediatric hematologist, one representative from each of the four medical schools in the state, the Deputy Secretary for Health or his designee, one representative from the Children's Medical Services Program Office, and one representative from the Developmental Services Program Office. All appointments shall be for a term of 4 years. The chairperson of the council shall be elected from the membership of the council and shall serve for a period of 2 years. The council shall meet at least semiannually or upon the call of the chairperson. The council may establish ad hoc or temporary technical advisory groups to

assist the council with specific topics which come before the council. Council members shall serve without pay. Pursuant to the provisions of s. 112.061, the council members are entitled to be reimbursed for per diem and travel expenses. It is the purpose of the council to advise the department about:

(a) Conditions for which testing should be included under the screening program and the genetics program;

(b) Procedures for collection and transmission of specimens and recording of results; and

(c) Methods whereby screening programs and genetics services for children now provided or proposed to be offered in the state may be more effectively evaluated, coordinated, and consolidated.

Section 95. Effective upon this act becoming a law, subsection (1) of section 383.011, Florida Statutes, is amended to read:

383.011 Administration of maternal and child health programs.—

(1) The Department of Health and Rehabilitative Services is designated as the state agency for:

(a) Administering or providing for maternal and child health services to provide periodic prenatal care for patients who are at low or medium risk of complications during pregnancy and to provide referrals to higher level medical facilities for those patients who develop medical conditions for which treatment is beyond the scope and capabilities of the county public health units.

(b) Administering or providing for periodic medical examinations, nursing appraisals, and nutrition counseling on infant and child patients to assess developmental progress and general health conditions; administering or providing for treatment for health complications when such treatment is within the scope and capabilities of the county public health units or Children's Medical Services.

(c) Administering and providing for the expansion of the maternal and child health services to include pediatric primary care programs subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.

(d) Administering and providing for prenatal and infant health care delivery services through county public health units or subcontractors for the provision of the following enhanced services for medically and socially high-risk clients subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216:

1. Case finding or outreach.

2. Assessment of health, social, environmental, and behavioral risk factors.

3. Case management utilizing a service delivery plan.

4. Home visiting to support the delivery of and participation in prenatal and infant primary health care services.

5. Childbirth and parenting education.

(e) The department shall establish in each county public health unit a Healthy Start Care Coordination Program in which a care coordinator is responsible for receiving screening reports and risk-assessment reports from the Office of Vital Statistics; conducting assessments as part of a multidisciplinary team, where appropriate; providing technical assistance to the district prenatal and infant care coalitions; directing family outreach efforts; and coordinating the provision of services within and outside the department using the plan developed by the coalition. The care coordination process must include, at a minimum, family outreach workers and health paraprofessionals who will assist in providing the following enhanced services to pregnant women, infants, and their families that are determined to be at potential risk by the department's screening instrument: case finding or outreach; assessment of health, social, environmental, and behavioral risk factors; case management utilizing the family support plan; home visiting to support the delivery of and participation in prenatal and infant primary care services; childbirth and parenting education; counseling; and social services, as appropriate. Family outreach workers may include social work professionals or nurses with public health education and counseling experience. Paraprofessionals may include resource mothers and fathers, trained health aides, and parent educators. The care coordination program shall be developed in a coordinated, nonduplicative manner with the Developmental Evaluation and Intervention Program of Children's Medical Services, using the local assessment findings and plans of the prenatal and infant care coalitions and the programs and services established in chapter 411, Pub. L. No. 99-457, and this chapter.

1. Families determined to be at potential risk based on the thresholds established in the department's screening instrument must be notified by the department of the determination and recommendations for follow-up services. All Medicaid-eligible families shall receive Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services of the Florida Medicaid Program to help ensure continuity of care. All other families identified at potential risk shall be directed to seek additional health care follow-up visits as provided under s. 627.6579. A family identified as a family at potential risk is eligible for enhanced services under the care coordination process within the resources allocated, if it is not already receiving services from the Developmental Evaluation and Intervention Program. The department shall adopt rules regulating the assignment of family outreach workers and paraprofessionals based on the thresholds established in the department's risk-assessment tool.

2. As part of the care coordination process, the department must ensure that subsequent screenings are conducted for those families identified as families at potential risk. Procedures for subsequent screenings of all infants and toddlers must be consistent with the established periodicity schedule and the level of risk. Screening programs must be conducted in accessible locations, such as child care centers, local schools, teenage pregnancy programs, community centers, and county public health units. Care coordination must also include initiatives to provide immunizations in accessible locations. Such initiatives must address ways to ensure that children not currently being served by immunization efforts are reached.

3. The provision of services under this section must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter.

(f)~~(e)~~ Receiving the federal maternal and child health and preventive health services block grant funds.

(g)~~(d)~~ Receiving the federal funds for the "Special Supplemental Food Program for Women, Infants, and Children," or WIC, authorized by the Child Nutrition Act of 1966, as amended, and for administering the statewide WIC program. (The WIC program provides nutrition education and supplemental foods, by means of food instruments called checks that are redeemed by authorized food vendors, to participants certified by the department as pregnant, breast-feeding, or postpartum women; infants; or children.)

Section 96. Effective upon this act becoming a law, subsection (7) is added to section 383.013, Florida Statutes, to read:

383.013 Prenatal care.—The Department of Health and Rehabilitative Services shall:

(7) Provide regional perinatal intensive care satellite clinics to deliver level III obstetric outpatient services to women diagnosed as being high risk, which includes an interdisciplinary team to deliver specialized high-risk obstetric care. The provision of satellite clinics is subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.

Section 97. Effective upon this act becoming a law, subsections (2) and (4) of section 383.215, Florida Statutes, are amended to read:

383.215 Developmental intervention and parent support and training programs.—

(2) It is the intent of the Legislature to establish developmental intervention and parent support and training programs at all Level III regional perinatal intensive care centers and *at hospitals with level II neonatal* ~~stepdown perinatal~~ intensive care *units* ~~centers~~, in order that families with high-risk or handicapped infants may gain the services and skills they need to support their infant. *It is also the intent of the Legislature to establish Developmental Evaluation and Intervention (DEI) programs at hospitals with level II neonatal intensive care units. The provision of developmental evaluation and intervention care units is subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.*

(4) The developmental intervention and family support and training programs shall be established in conjunction with the Level III regional perinatal intensive care centers. *Developmental Evaluation and Intervention (DEI)* ~~Additional~~ programs *shall also* ~~may~~ be established at *hospitals with level II neonatal* ~~stepdown perinatal~~ intensive care *units* ~~centers~~ based on geographic location and population. *The provision of developmental evaluation and intervention care units is subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.* Each program shall have a program director and the necessary staff. The program director shall establish and coordinate the developmental intervention and family support and training program. The program shall include:

(a) In-hospital intervention services, parent support and training, and individual and family service planning.

(b) Interdisciplinary team meetings on a regular basis to develop and update the individual and family service plan.

(c) Discharge planning by the interdisciplinary team.

(d) Education and training for neonatal intensive care unit staff, volunteers, and others, as needed, in order to expand the services provided to high-risk or handicapped infants and their families.

(e) Followup intervention services after hospital discharge, to aid the family and high-risk or handicapped infant's transition into the community. These services shall include home intervention services and non-home-based intervention services, both contractual and voluntary.

(f) Coordination of services with community providers.

(g) Educational materials about infant care, infant growth and development, community resources, medical conditions and treatments, and family advocacy.

Section 98. Effective upon this act becoming a law, section 383.216, Florida Statutes, is created to read:

383.216 Community-based prenatal and infant health care.—

(1) The Department of Health and Rehabilitative Services shall cooperate with localities which wish to establish prenatal and infant health care coalitions, and shall acknowledge and incorporate, if appropriate, existing community children's services organizations, pursuant to this section within the resources allocated. The purpose of this program is to establish a partnership among the private sector, the public sector, state government, local government, community alliances, and maternal and child health care providers, for the provision of coordinated community-based prenatal and infant health care. The prenatal and infant health care coalitions must work in a coordinated, nonduplicative manner with local health planning councils established pursuant to s. 381.703.

(2) Each prenatal and infant health care coalition shall develop, in coordination with the Department of Health and Rehabilitative Services, a plan which shall include at a minimum provision to:

(a) Perform community assessments, using the Planned Approach to Community Health (PATCH) process, to identify the local need for comprehensive preventive and primary prenatal and infant health care. These assessments shall be used to:

1. Determine the priority target groups for receipt of care.

2. Determine outcome performance objectives jointly with the department.

3. Identify potential local providers of services.

4. Determine the type of services required to serve the identified priority target groups.

5. Identify the unmet need for services for the identified priority target groups.

(b) Design a prenatal and infant health care services delivery plan which is consistent with local community objectives and this section.

(c) Solicit and select local service providers based on reliability and availability, and define the role of each in the services delivery plan.

(d) Determine the allocation of available federal, state, and local resources to prenatal and infant health care providers.

(e) Review, monitor, and advise the department concerning the performance of the services delivery system, and make any necessary annual adjustments in the design of the delivery system, the provider composition, the targeting of services, and other factors necessary for achieving projected outcomes.

(f) Build broad-based community support.

(3) Supervision of the prenatal and infant health care coalitions is the responsibility of the department. The department shall:

(a) Assist in the formation and development of the coalitions.

(b) Define the core services package so that it is consistent with the prenatal and infant health care services delivery plan.

(c) Provide data and technical assistance.

(d) Assure implementation of a quality management system within the provider coalition.

(e) Define statewide, uniform eligibility and fee schedules.

(f) Evaluate provider performance based on outcome measures established by the prenatal and infant health care coalition and the department.

(4) In those communities which do not elect to establish a prenatal and infant health care coalition, the Department of Health and Rehabilitative Services is responsible for all of the functions delegated to the coalitions in this section.

(5) The membership of each prenatal and infant health care coalition shall represent health care providers, the recipient community, and the community at large; shall represent the racial, ethnic, and gender composition of the community; and shall include at least the following:

(a) Consumers of family planning, primary care, or prenatal care services, at least two of whom are low-income or Medicaid eligible.

(b) Health care providers, including:

1. County public health units.

2. Migrant and community health centers.

3. Hospitals.

4. Local medical societies.

5. Local health planning organizations.

(c) Local health advocacy interest groups and community organizations.

(d) County and municipal governments.

(e) Social service organizations.

(f) Local education communities.

(6) Prenatal and infant health care coalitions may be established for single counties or for services delivery catchment areas. A prenatal and infant health care coalition shall be initiated at the local level on a voluntary basis. Once a coalition has been organized locally and includes the membership specified in subsection (5), the coalition must submit a list of its members to the Secretary of Health and Rehabilitative Services to carry out the responsibilities outlined in this section.

(7) Effective January 1, 1992, the Department of Health and Rehabilitative Services shall provide up to $150,000 to each prenatal and infant health care coalition that petitions for recognition, meets the membership criteria, demonstrates the commitment of all the designated members to participate in the coalition, and provides a local cash or in-kind contribution match of 25 percent of the costs of the coalition. An in-kind contribution match may be in the form of staff time, office facilities, or supplies or other materials necessary for the functioning of the coalition.

(8) Local prenatal and infant health care coalitions may hire staff or contract for independent staffing and support to enable them to carry out the objectives of this section. Staff shall have knowledge and expertise in community health and related resources and planning, grant writing, public information and communication techniques, organizational development, and data compilation and analysis.

(9) Local prenatal and infant health care coalitions shall incorporate as not-for-profit corporations for the purpose of seeking and receiving grants from federal, state, and local government and other contributors.

(10) The Department of Health and Rehabilitative Services shall adopt rules as necessary to implement this section, including rules defining acceptable "in-kind" contributions.

Section 99. Effective upon this act becoming a law, section 383.2161, Florida Statutes, is created to read:

383.2161 Maternal and child health report.—Beginning in 1993, the Department of Health and Rehabilitative Services annually shall compile and analyze the risk information collected by the Office of Vital Statistics and the district prenatal and infant care coalitions and shall prepare and submit to the Legislature by January 2 a report that includes, but is not limited to:

(1) The number of families identified as families at potential risk;

(2) The number of families that receive family outreach services;

(3) The increase in demand for services; and

(4) The unmet need for services for identified target groups.

Section 100. *(1) The Department of Health and Rehabilitative Services shall develop, for submission to the Legislature by December 1, 1991, a plan for decategorizing the resources provided to two districts into a single child and maternal health budget. The plan must establish procedures to allow for allocating resources on the basis of child and maternal welfare concerns, as opposed to specific program categories, using the assessment findings of the district prenatal and infant care coalitions established in section 383.135, Florida Statutes.*

(2) The department shall develop, as a part of this plan, an alternative reimbursement methodology for providers that provide performance-based payment and payment that rewards providers who develop social services and educational linkages and support services. The methodology shall be designed to enhance services by increasing resource flexibility within current budgetary levels. The department shall develop this plan in consultation with the appropriate substantive committees in the Legislature and state advisory councils.

Section 101. Effective upon this act becoming a law, paragraph (k) is added to subsection (1) of section 427.012, Florida Statutes, to read:

427.012 Transportation Disadvantaged Commission.—There is created a Transportation Disadvantaged Commission in the Department of Transportation.

(1) The commission shall consist of the following members:

(k) One member of the Early Childhood Council. Such person shall be appointed by the Governor to represent maternal and child health care providers and shall be appointed to serve a term of 4 years.

Section 102. Except as otherwise provided herein, this part shall take effect upon becoming a law.

Part V
ACCESS TO HEALTH CARE
ACT OF 1991

WHEREAS, while the Federal Government struggles with its pressing spending priorities, which include the problems caused by the lack of health insurance for millions of Americans, it is the states which must cope with the visible effects of uncompensated health care and overburdened health providers and facilities, and

WHEREAS, it is the intent of the Legislature to provide increased access to health care by authorizing contractual arrangements whereby health care services are provided through an agency relationship between the provider and a governmental contractor, NOW, THEREFORE,

Section 103. Effective upon this act becoming a law and applicable to incidents occurring on or after the effective date, section 766.1115, Florida Statutes, is created to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

(1) This section may be cited as the "Access to Health Care Act of 1991."

(2) As used in this section:

(a) The term "health care provider" or "provider" means any:

1. Hospital licensed under chapter 395.

2. Physician licensed, or physician's assistant certified, under chapter 458.

3. Osteopathic physician licensed, or physician's assistant certified, under chapter 459.

4. Podiatrist licensed under chapter 461.

5. Health maintenance organization certificated under part II of chapter 641.

6. Ambulatory surgical center licensed under chapter 395.

7. Chiropractor licensed under chapter 460.

8. Psychologist licensed under chapter 490.

9. Optometrist licensed under chapter 463.

10. Optician licensed under chapter 484.

11. Physical therapy practitioner licensed under chapter 486.

12. Dentist licensed under chapter 466.

13. Pharmacist licensed under chapter 465.

14. Registered nurse, nurse midwife, licensed practical nurse, and advanced registered nurse practitioner licensed or registered under the provisions of chapter 464.

15. Midwife licensed under chapter 467

16. Birth center licensed under chapter 383.

17. Other medical facility which is a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment, and which includes an office maintained by a provider for the provision of health care services, but excluding any facility regulated pursuant to chapter 400.

The term includes any nonprofit corporation operating pursuant to section 501(c) of the Internal Revenue Code to provide health care services by licensed professionals as listed in this paragraph, and any volunteer corporation or health care provider providing such services. In order to be a provider as contemplated by this section, regardless of whether the provider is a volunteer or is compensated and, if compensated, regardless of the provider's election under subparagraph (3)(b)8., the provider must be selected by a governmental contractor to provide health care services pursuant to an agency agreement with the governmental contractor entered into in accordance with the requirements of this section. This section does not apply to physicians or corporate medical groups providing radiology or anesthesiology care pursuant to an exclusive care contract which prohibits competition by other similarly skilled medical specialists.

(b) "Contract" means an agreement entered into in compliance with the provisions of this section by a health care provider with any entity of state or local government, or of any political subdivision thereof, to provide health care services as an agent of such governmental contractor. The contract shall be either:

1. A contract for the provision of volunteer services, which for purposes of this section means uncompensated voluntary services provided to recipients selected by the governmental contractor, such as school team physicians selected and contracted with by the school board; or

2. A contract for the provision of compensated services, which for purposes of this section means services subject to paragraph (3)(b)8. provided to low-income recipients selected by the governmental contractor.

(c) "Governmental contractor" means any entity of state or local government, or of any political subdivision thereof, which enters into an agency agreement with a provider pursuant to the requirements of this section for the provision of health care services.

(d) "Low-income" means:

1. Medicaid-eligible under Florida law;

2. Medically indigent as defined in s. 407.002(18); or

3. Eligible for reduced-rate health care services pursuant to the terms of the governmental contract as approved by, and on a form promulgated by, the Department of Health and Rehabilitative Services.

(3)(a) A health care provider which enters into an agreement with any entity of state or local government, or of any political subdivision thereof, to provide health care services as an agent of such entity, shall be an agent for purposes of s. 768.28(9), while in compliance with the contract and acting within the scope of duties pursuant to the contract, so long as the contract contains the provisions required by this section.

(b) The agreement shall be pursuant to contract in terms approved by, and on a form promulgated by, the Department of Health and Rehabilitative Services. The contract shall provide for:

1. The right of control of the governmental contractor over the professional conduct of any health care provider providing services pursuant to the contract, including the power of dismissal or termination.

2. Access by the governmental contractor to the patient records of any health care provider providing services pursuant to the contract.

3. Reporting of adverse incidents and information on outcomes of treatment provided by any health care provider providing services pursuant to the contract. Patient medical records, adverse incidence reports, and information on outcome of treatments identifying specific patients obtained by governmental entities are confidential and exempt from the provisions of s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

4. Payment for health care services of providers who have contracted for the provision of compensated services solely by the governmental contractor, subject to the provisions of subparagraph (3)(b)8.

5.a. Patient selection and initial referral solely by the governmental contractor, and acceptance by the provider of all referred patients. However, the number of patients to be accepted may be limited by agreement, and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

b. If emergency care is required, the patient need not be referred prior to receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever is later.

c. If it is necessary that a patient be referred from a contract provider to a noncontract provider, the immunity of the contract provider shall extend to the noncontract provider until the patient is stabilized and medically capable of referral back to the contract provider.

d. The Department of Health and Rehabilitative Services shall promulgate rules which provide patient screening criteria, taking into consideration modalities of treatment, diagnostic groups, and other factors relevant to establishing an equitable process for medically appropriate patient referrals designed to maximize access to health care services.

6. Patient care, including any followup or hospital care, to be subject to approval by the governmental contractor.

7. Provider to be subject to supervision and regular inspection by the governmental contractor.

8. With respect to any provider receiving any compensation under the contract:

a. Provider's Medicaid or other contract health care services compensation to be paid solely to or on behalf of the governmental contractor, the provider receiving a maximum of 90 percent of the applicable rate, with half the remaining amount deposited into a claims fund maintained by the governmental contractor and the other half deposited into a trust fund established and maintained by the Department of Health and Rehabilitative Services for the payment of excess claims approved by the Legislature; or

b. At least 10 percent of the provider's contractually-provided health care services to be provided, without any compensation from any source, to nonMedicaid-eligible recipients who are medically indigent as defined in s. 407.002(18).

However, for the purpose of creating alternate compliance methodologies designed to maximize access to all health care services, the Department of Health and Rehabilitative Services shall have the discretion to develop rules that contemplate specialty practices which provide high-risk, high-cost, or difficult to obtain health care services.

9. A copy of the contract to the Department of Health and Rehabilitative Services and the Department of Professional Regulation.

All information, records, and reports required by this paragraph shall be available to the Department of Health and Rehabilitative Services for purposes of subsection (7).

(4) The governmental contractor shall provide written notice to all concerned persons that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider, or of any employee or agent thereof, acting within the scope of duties pursuant to the contract, or of any noncontract provider to which the patient is referred by the provider pursuant to subparagraph (3)(b)5., shall be by action pursuant to the provisions of s. 768.28.

(5) The governmental contractor shall establish a quality assurance program to monitor the quality of services provided under any contracts of agency with a provider pursuant to this section.

(6) The Department of Health and Rehabilitative Services shall adopt rules designed to implement this section in a manner consistent with its purpose to provide and facilitate access to appropriate, safe, and cost-effective health care services. The Department of Professional Regulation and each governmental contractor shall assist the Department of Health and Rehabilitative Services as necessary in the development of rules needed for the implementation of agency agreements pursuant to the provisions of this section.

(7) A patient health care treatment and access evaluation methodology shall be developed as follows:

(a) Each entity which is a governmental contractor shall transmit to the Department of Health and Rehabilitative Services a copy of each contract entered into pursuant to this section, within 2 calendar weeks after the contract is executed.

(b) The Department of Health and Rehabilitative Services shall establish a patient health care treatment and access evaluation methodology which shall evaluate the efficacy of the provision of health care services to low-income persons by providers under contract with governmental entities pursuant to agency agreements entered into in compliance with the provisions of this section, and shall analyze and graph changes in patterns of access and treatment outcomes with respect to health care for low-income persons occurring as a result thereof.

(c) The methodology shall be designed to promote efficient and effective in-depth analysis of access and treatment outcomes with respect to health care for low-income persons pursuant to agency agreements as contemplated by this section. The department shall develop rules as necessary for the implementation of the methodology.

(d) Annually beginning January 1, 1994, the department shall provide to the President of the Senate, the Speaker of the House of Representatives, and the minority leaders and relevant substantive committee chairs of both houses, a detailed summation of the information obtained through the patient health care treatment and access evaluation methodology.

(8) This section is repealed on July 1, 1996, and shall be reviewed by the Legislature prior to that date.

Section 104. Effective upon this act becoming a law and applicable to incidents occurring on or after the effective date, paragraph (b) of subsection (9) of section 768.28, Florida Statutes, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions.—

(5) The state and its agencies and subdivisions shall be liable for tort claims in the same manner and to the same extent as a private individual

under like circumstances, but liability shall not include punitive damages or interest for the period before judgment. Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $100,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $200,000. However, a judgment or judgments may be claimed and rendered in excess of these amounts and may be settled and paid pursuant to this act up to $100,000 or $200,000, as the case may be; and that portion of the judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole only by further act of the Legislature. Notwithstanding the limited waiver of sovereign immunity provided herein, the state or an agency or subdivision thereof may agree, within the limits of insurance coverage provided, to settle a claim made or a judgment rendered against it without further action by the Legislature, but the state or agency or subdivision thereof shall not be deemed to have waived any defense of sovereign immunity or to have increased the limits of its liability as a result of its obtaining insurance coverage for tortious acts in excess of the $100,000 or $200,000 waiver provided above. The limitations of liability set forth in this subsection shall apply to the state and its agencies and subdivisions whether or not the state or its agencies or subdivisions possessed sovereign immunity before July 1, 1974.

(9)(a) No officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. However, such officer, employee, or agent shall be considered an adverse witness in a tort action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of his employment or function. The exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state or any of its subdivisions or constitutional officers shall be by action against the governmental entity, or the head of such entity in his official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless such act or omission was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. The state or its subdivisions shall not be liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, *any provider of health care services pursuant to s. 766 1115; and* any public defender or his employee or agent, including, among others, an assistant public defender and an investigator.

Section 105. For the purpose of incorporating the amendment to section 768.28, Florida Statutes, in references thereto, the sections or subdivisions of Florida Statutes set forth below are reenacted to read:

766.203 Presuit investigation of medical negligence claims and defenses by prospective parties.—

(1) Presuit investigation of medical negligence claims and defenses pursuant to this section and ss. 766.204-766.206 shall apply to all medical negligence, including dental negligence, claims and defenses. This shall include:

(a) Rights of action under s. 768.19 and defenses thereto.

(b) Rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28 and defenses thereto.

766.207 Voluntary binding arbitration of medical negligence claims.—

(1) Voluntary binding arbitration pursuant to this section and ss. 766.208-766.212 shall not apply to rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28.

Section 106. Effective upon this act becoming a law and applicable to incidents occurring on or after the effective date, subsection (1) of section 766.102, Florida Statutes, is amended to read:

766.102 Medical negligence; standards of recovery.—

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in *s. 766.1115(1)(a)* ~~s. 768.50(2)(b)~~, the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Section 107. Paragraphs (b), (c), and (g) of subsection (3) of section 381.703, Florida Statutes, are amended to read:

381.703 Local and state health planning.—

(3) FUNDING.—

(b)1. A hospital licensed under chapter 395, a nursing home licensed under chapter 400, and an adult congregate living facility licensed under chapter 400 shall be assessed an annual fee based on number of beds.

2. All other facilities and organizations listed in paragraph (a) shall each be assessed *an annual fee of $150* ~~a graduated annual fee based on volume of service~~.

3. Facilities operated by the Department of Health and Rehabilitative Services or the Department of Corrections and any hospital which meets the definition of rural hospital pursuant to s. 395.102(2) are exempt from the assessment required in this subsection.

(c)1. The department shall, by rule, establish fees for hospitals and nursing homes based on an assessment of $2 per bed. However, no such facility shall be assessed more than a total of $500 under this subsection.

2. The department shall, by rule, establish fees for adult congregate living facilities based on an assessment of $1 per bed. However, no such facility shall be assessed more than a total of $150 under this subsection.

3. The department shall, by rule, establish *an annual fee of $150* ~~graduated fees~~ for all other facilities and organizations listed in paragraph (a) ~~based on volume of service. Such fees shall not exceed a maximum of $150 for any facility or organization~~.

(g) The department shall *deposit in the Local and State Health Trust Fund all health care facility assessments that are assessed under this subsection and proceeds from the certificate-of-need application fees which are sufficient to maintain the aggregate funding level for the local health councils and the Statewide Health Council as specified in the General Appropriations Act for the 1990-1991 fiscal year, plus any increase specifically mandated by the Legislature for the Statewide Health Council. The remaining certificate-of-need application fees shall be deposited in a trust account administered by the department and may be used only for the purpose of administering the Health Facility and Services Development Act.*, ~~on an ongoing basis, deposit 90 percent of all certificate-of-need application fees and 100 percent of health care facilities assessments assessed pursuant to this subsection in the Local and State Health Trust Fund~~.

Section 108. Section 381.708, Florida Statutes, is amended to read:

381.708 Fees.—The department shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the Statewide Health Council, the functions of the local health councils, and the activities of the department *and shall be allocated as provided in s. 381.703.* The fee shall be determined as follows:

(1) A minimum base fee of *$5,000* ~~$750~~.

(2) In addition to the base fee of *$5,000* ~~$750~~, *0.015* ~~0.006~~ of each dollar of proposed expenditure, except that *a* ~~no~~ fee *may not* ~~shall~~ exceed *$22,000* ~~$10,000~~.

Section 109. Subsection (3) of section 390.014, Florida Statutes, is amended to read:

390.014 Licenses; fees, display, etc.—

(3) The annual license fee required for a clinic shall be nonrefundable and shall be *reasonably calculated to cover the cost of regulation under this chapter, but may* ~~equal to $1 times the authorized patient capacity of the clinic; however, the fee shall~~ not be less than $35~~,~~ nor more than *$250* ~~$75~~.

Section 110. Subsection (2) of section 395.004, Florida Statutes, is amended to read:

395.004 Application for license, disposition of fees; expenses.—

(2) Each application for a general hospital license, specialty hospital license, or ambulatory surgical center license, or renewal thereof, shall be accompanied by a license fee, in accordance with the following schedule:

(a) The biennial license and license renewal fee required of a facility licensed under this part *shall be reasonably calculated to cover the cost of regulation under this part and* shall be established by rule at the rate of not less than $9.50 per hospital bed, nor more than *$30* ~~$15~~ per hospital bed, except that the minimum license fee hereunder shall be *$1,500* ~~$475~~ and the total fees collected from all licensed facilities *may* ~~shall~~ not exceed the cost of properly carrying out the provisions of this part.

(b) Such fees shall be payable to the department and shall be deposited in the Hospital Licensure Trust Fund for the sole purpose of carrying out the provisions of this part.

Section 111. Paragraph (a) of subsection (2) of section 395.007, Florida Statutes, is amended to read:

395.007 Construction inspections; plan submission and approval; fees.—

(2)(a) The department is authorized to charge *an initial fee of $2,000 for review of plans and construction on all projects, no part of which is refundable. The department may also collect* a fee, not to exceed 1 percent of the estimated construction cost or the actual cost of review, whichever is less, for *the portion of the review which encompasses initial review through the initial revised construction document review. The department is further authorized to collect its actual costs on all subsequent portions of the review and construction inspections. Initial* ~~services rendered in conducting the review of plans and specifications for each new project, in an amount sufficient to cover the cost of necessary architectural and engineering services to meet the requirements of this section.~~ fee payment shall accompany the initial submission of ~~final~~ plans and specifications. *Any subsequent payment that is due is payable upon receipt of the invoice from the department.*

Section 112. Subsection (3) of section 400.062, Florida Statutes, is amended to read:

400.062 License required; fee; disposition; display; transfer.—

(3) The annual license fee required for each license issued under this part shall be comprised of two parts. Part I of the license fee shall be the basic license fee. The rate per bed for the basic license fee shall be established annually~~;~~ and *must be reasonably calculated to cover the cost of regulation under this part, but may not exceed $35 per bed.*~~, in establishing such rate, the department shall divide one-third of the total fiscal year's legislative appropriation for carrying out the provisions of this part by the total number of beds to be licensed under this part.~~ Part II of the license fee shall be the resident protection fee, which shall be at the rate of not less than 25 cents per bed. The rate per bed shall be the minimum rate per bed, and such rate shall remain in effect until the effective date of a rate per bed *adopted* ~~promulgated~~ by rule by the department pursuant to this part. At such time as the amount on deposit in the Resident Protection Trust Fund is less than $500,000, the department may *adopt* ~~promulgate~~ rules to establish a rate which may not exceed $10 per bed. The rate per bed shall revert back to the minimum rate per bed when the amount on deposit in the Resident Protection Trust Fund reaches $500,000, except that any rate established by rule shall remain in effect until such time as the rate has been equally required for each license issued under this part. Any amount in the fund in excess of $800,000 shall revert to the Nursing Home and Related Facilities Licensure Trust Fund and may not be expended without prior approval of the Legislature. The department may prorate the annual license fee for those licenses which it issues under this part for less than 1 year. Funds generated by license fees collected in accordance with this section shall be deposited in the following manner:

(a) The basic license fee collected shall be deposited in the Nursing Homes and Related Facilities Licensure Trust Fund, which is hereby established for the sole purpose of carrying out the provisions of this part.

(b) The resident protection fee collected shall be deposited in the Resident Protection Trust Fund for the sole purpose of paying, in accordance with the provisions of s. 400.063, for the appropriate alternate placement, care, and treatment of a resident removed from a nursing home facility on a temporary, emergency basis or for the maintenance and care of residents in a nursing home facility pending removal and alternate placement.

Section 113. Subsection (8) of section 400.23, Florida Statutes, 1990 Supplement, is amended to read:

400.23 Rules; minimum standards; evaluation and rating system; fee for review of plans.—

(8) The department is authorized to charge *an initial fee of $2,000 for review of plans and construction on all projects, no part of which is refundable. The department may also collect* a fee, not to exceed *1* ~~0.5~~ percent of the estimated construction cost or the actual cost of review, whichever is less, for *the portion of the review which encompasses initial review through the initial revised construction document review. The department is further authorized to collect its actual costs on all subsequent portions of the review and construction inspections. Initial* ~~services rendered in conducting the review of plans and specifications for each new project, in an amount sufficient to cover the costs of purchasing necessary additional architectural and engineering services to meet the requirements of this section.~~ fee payment shall accompany the initial submission of plans and specifications. *Any subsequent payment that is due is payable upon receipt of the invoice from the department.* Notwithstanding any other provisions of law to the contrary, all money received by the department pursuant to the provisions of this section shall be deemed to be trust funds, to be held and applied solely for the operations required under this section.

Section 114. Paragraph (a) of subsection (4) of section 400.407, Florida Statutes, is amended to read:

400.407 License required; fee, display.—

(4)(a) The *biennial* ~~annual~~ license fee required of a facility shall be *$240* ~~$100~~ per license, with an additional fee of *$30* ~~$5~~ per resident based on the total licensed resident capacity of the facility, *except that a reduced additional fee of $10 per resident shall be assessed for beds designated for recipients of optional state supplementation payments provided for in s. 409.212.* The total fee shall not exceed *$10,000* ~~$1,000~~, no part of which shall be returned to the facility. ~~Beginning July 1, 1988, the department may adjust the $100 annual license fee and the maximum total license fee once each year by not more than the average rate of inflation for the 12 months immediately preceding the increase.~~

Section 115. Section 400.418, Florida Statutes, is amended to read:

400.418 Disposition of fees and administrative fines.—Income from license fees, late fees, and administrative fines generated pursuant to ss. 400.407, 400.417 and 400.419 shall be deposited in *a trust fund administered by the* ~~the Licensure Fees Trust Fund of the~~ department. Such funds shall be directed to and used by the department for the following purposes:

(1) Up to 50 percent of the trust funds accrued each fiscal year may be used to offset the expenses of receivership, pursuant to s. 400.422, if the court determines that the income and assets of the facility are insufficient to provide for adequate management and operation.

(2) An amount of $5,000 of the trust funds accrued each year shall be allocated to pay for inspection-related physical and mental health examinations requested by the department pursuant to s. 400.426 for residents who are either recipients of supplemental security income or have monthly incomes not in excess of the maximum combined federal and state cash subsidies available to supplemental security income recipients, as provided for in s. 409.212. Such funds shall only be used where the resident is ineligible for Medicaid.

(3) The balance of trust funds accrued each year may be used to offset the costs of the licensure program, including the costs of conducting background investigations, verifying information submitted, and defraying the costs of processing the names of applicants.

Section 116. Subsection (2) of section 400.467, Florida Statutes, 1990 Supplement, is amended to read:

400.467 License required; fee; display.—

(2) The license fee and annual renewal fee required of an agency shall be nonrefundable and in an amount determined by the department to be sufficient to cover the department's costs in carrying out its responsibilities under this part but not to exceed *$1,000* ~~$500~~. However, state, county, or municipal governments applying for licenses under this part are exempt from the payment of license fees.

Section 117. Subsection (2) of section 400.605, Florida Statutes, is amended to read:

400.605 Administration; forms; fees; rules; inspections; fines.—The administration of this act is vested in the Department of Health and Rehabilitative Services, which shall:

(2) Collect in advance (and the applicant so served shall pay to it in advance) at the time of filing an application for a license or at the time of renewal of a license a fee *which must be reasonably calculated to cover the cost of regulation under this part, but may not exceed $600 per program* ~~of $100~~.

Section 118. Subsection (5) of section 483.172, Florida Statutes, is amended to read:

483.172 License fees.—The department shall collect fees for all licenses issued under this part. The fee schedule for fiscal year 1983-1984 shall be the minimum fees provided herein, and such schedule shall remain in effect until the effective date of a fee schedule adopted by rule by the department pursuant to this part. The fee schedule for licensure of clinical laboratories shall be increased annually in substantially equal increments to produce, by fiscal year 1985-1986, an overall fee schedule in which fees from licensure of clinical laboratories are sufficient to carry out the responsibilities of the department for regulation of clinical laboratories and fees from licensure of clinical laboratory personnel are sufficient to carry out the responsibilities of the department for regulation of clinical laboratory personnel. Each fee shall be due at the time of application and shall be payable to the department to be deposited in a trust fund administered by the department and used only for the purposes of this chapter. The fee schedule is as follows:

(5) For licensure as a clinical laboratory, an annual fee of not less than $210 or more than *$1,200* ~~$1,000~~. No separate licensure fee shall be paid by any branch office, mobile donor unit, or transfusion service operated by a blood bank when the principal location of the blood bank is licensed under this part. For late filing of an application for renewal, a fee of $100. In any licensure period in which the department accepts an equivalent inspection of a blood bank pursuant to s. 483.061, such blood bank shall pay only a fee of $50.

Section 119. Section 627.4106, Florida Statutes, is created to read:

627.4106 Small group health insurance; rates; restrictions.—

(1) PURPOSE.—The intent of this section is to promote the availability of health insurance coverage to small employers through the participation of more insurers in the market, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

(2) DEFINITIONS.—As used in this section:

(a) "Small employer" means any person actively engaged in business that, on at least 50 percent of its working days during the preceding year, employed no more than 25 eligible employees. In determining the number of eligible employees, persons that are affiliated persons or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

(b) "Carrier" means any person who provides health insurance in this state. "Carrier" includes a licensed insurance company or a health maintenance organization.

(c) "Health benefit plan" means any hospital or medical expense incurred policy or certificate, any hospital or medical service plan contract, or any health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation and employers' liability or similar insurance; or automobile medical-payment insurance.

(d) "Small employer carrier" means any carrier that offers health benefit plans covering the employees of a small employer.

(e) "Case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status since issue of a certificate, and duration of coverage are not case characteristics.

(f) "Department" means the Department of Insurance.

(g) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics, excluding claim experience and health status, for health benefit plans with the same or similar coverage.

(h) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered by the small employer carrier to small employers with similar case characteristics, excluding claim experience and health status, for newly issued health benefit plans with the same or similar coverage.

(i) "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetical average of the applicable base premium rate and the corresponding highest premium rate.

(j) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

1. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

a. Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

b. Have been acquired from another small employer carrier as a distinct grouping of plans;

c. Are provided through an association with membership of not less than 25 small employers that has been formed for purposes other than obtaining insurance; or

d. Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in sub-subparagraph (4)(a)2.a.

2. A small employer carrier may establish no more than two additional groupings under each of the sub-subparagraphs in subparagraph 1. on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

3. The department may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the department that this action would enhance the efficiency and fairness of the small employer insurance marketplace.

(k) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individuals acceptable to the department that a small employer carrier is in compliance with the provisions of subsection (4), based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

(l) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(3) HEALTH INSURANCE PLANS SUBJECT TO THIS SECTION.—

(a) Except as provided in paragraph (b) and notwithstanding any other provision of this part, the provisions of this section apply to any health benefit plan provided by a small employer carrier which provides coverage to one or more employees of a small employer.

(b) The provisions of this section do not apply to nongroup health insurance policies that are subject to policy form and premium rate approval as provided in s. 627.410.

(c) Notwithstanding s. 627.401(2), the provisions of this section and ss. 627.410 and 627.411 apply to any health benefit plan provided by a small employer carrier which provides coverage to one or more employees of a small employer regardless of whether the policy, certificate, or contract is issued or delivered outside this state if the health benefit plan covers employees or their covered dependents who are residents of this state.

(4) RESTRICTIONS RELATING TO PREMIUM RATES.—

(a) Premium rates for health benefit plans subject to this section are subject to the following provisions:

1. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent.

2. Subparagraph 1. does not apply to a class of business if all of the following apply:

a. The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status.

b. The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business.

c. The class of business is currently available for purchase.

3. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to these employers under the rating system for that class of business, may not vary from the index rate by more than 25 percent of the index rate.

4. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate.

b. An adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than 1 year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business.

c. Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

5. In the case of health benefit plans issued prior to October 1, 1991, a premium rate for a rating period may exceed the ranges described in subparagraph 1. or subparagraph 3. until October 1, 1996. In this case, the percentage increase in the premium rate charged to a small employer in this class of business for a new rating period may not exceed the sum of the following:

a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate.

b. Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(b) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(c) A small employer carrier may not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

(5) PROVISIONS ON RENEWABILITY OF COVERAGE.—

(a) Except as provided in paragraph (b), a health benefit plan subject to this section shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons:

1. Nonpayment of required premiums;

2. Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual or subscriber, or fraud or misrepresentation by the insured individual or subscriber or individual's or subscriber's representative;

3. Noncompliance with plan provisions;

4. The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

5. The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

(b) A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the insurance regulatory agency in each state in which an affected insured individual is known to reside at least 90 days prior to termination of coverage. A carrier that exercises its right to cease to renew all plans in a class of business may not:

1. Establish a new class of business for a period of 5 years after the nonrenewal of the plans without prior approval of the department; or

2. Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status, or duration of coverage.

(6) DISCLOSURE OF RATING PRACTICES AND RENEWABILITY PROVISIONS.—Each small employer carrier shall make reasonable disclosure in solicitations and sales materials provided to small employers of all the following:

(a) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees of the small employer or their dependents.

(b) The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, that affect changes in premium rates.

(c) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans.

(d) The provisions relating to renewability of coverage.

(7) MAINTENANCE OF RECORDS.—

(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the department each March 1 an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the certification shall be retained by the carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in paragraph (a) available to the department upon request.

(8) WAIVER OF REQUIREMENTS.—The department may suspend all or any part of the provisions of subsection (4) as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the department that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance

Section 120. Section 627.6693, Florida Statutes, 1990 Supplement, is amended to read:

627.6693 Small group basic health insurance policies.—

(1) As used in this section:

(a) "Small group basic health insurance policy" means a basic policy issued to any small employer or group of small employers.

(b) "Small employer" means one employer that employs fewer than 25 persons on a regular basis.

(c) "Group of small employers" means a group composed of two or more small employers that join together to purchase a small group basic health insurance policy.

(d) "Mandated benefits" means the benefits required under ss. *627.419(2), (3), and (4),* 627.6573, ~~627.6574,~~ 627.6612, 627.6616, 627.6617, 627.6618, 627.668, and 627.669.

(e) "Basic policy" means a group health insurance policy or health maintenance organization contract that is not required to contain any mandated benefits; however, a basic policy may contain any such mandated benefits.

(f) "Insurer" means any insurance company authorized to transact health insurance in this state.

(2) A group of individuals may be insured under a small group basic health insurance policy that complies with this section and other provisions of the Insurance Code.

(3) Each insurer and health maintenance organization transacting group health insurance or providing prepaid health care in this state shall make the following benefits available to the policyholder for an appropriate additional premium as part of the application under a small group basic health insurance policy:

(a) Coverage for the services of a chiropractic physician who performs procedures or services which are within the scope of a chiropractic physician's license, if the policy or contract provides coverage for such procedures or services.

(b) Coverage for the services of an optometrist who performs procedures or services which are within the scope of an optometrist's license, if the policy or contract provides coverage for such procedures or services.

(c) Coverage for the services of a podiatrist who performs procedures or services which are within the scope of a podiatrist's license, if the policy or contract provides coverage for such procedures or services.

(d) Coverage for the services of a dentist who performs procedures or services which are within the scope of a dentist's license, if the policy or contract provides coverage for such procedures or services.

(e)~~(a)~~ The coinsurance option provided under s. 627.6573.

~~(b) The maternity care coverage provided under s. 627.6574.~~

~~(c) The coverage for newborn children provided under s. 627.6575.~~

~~(d) The coverage for child health supervision services provided under s. 627.6579.~~

(f)~~(e)~~ The coverage for surgical procedures and devices incident to mastectomy provided under s. 627.6612.

~~(f) The coverage for handicapped children provided under s. 627.6615.~~

(g) The coverage for ambulatory surgical center services provided under s. 627.6616.

(h) The coverage for home health care services provided under s. 627.6617.

(i) The acupuncture coverage provided under s. 627.6618.

(j) Coverage for the level of benefits for mental and nervous disorders specified in s. 627.668(2) in addition to any other level of benefits that may be offered.

(k) Coverage for the level of benefits for alcoholism and drug dependency specified in s. 627.669(2) in addition to any other level of benefits that may be offered.

(4) A group of small employers may form a group for the limited purpose of purchasing a small group basic health insurance policy under this section. Such group shall be deemed to be an employee group under s. 627.653. No restriction shall be imposed on the formation of a group of small employers based on the location, profession, industry, or type of business conducted by the employers wishing to participate in the group.

(5) Any small group basic health insurance policy may insure the spouse or dependent children of an employee or group member, without regard to whether such employee or group member is insured under the policy.

(6) The provisions of this section shall control to the extent of any conflict with any other provisions of the Florida Statutes.

Section 121. *Section 627.4106, Florida Statutes, as created by this act, applies to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state on or after October 1, 1991, regardless of whether the policy providing such health benefit plans is issued in this or any other state. For the purposes of this section, the date a plan is continued is the first rating period that commences after October 1, 1991.*

Section 122. Except as otherwise provided herein, this part shall take effect upon this act becoming a law, and shall apply to incidents occurring on or after the effective date.

House Amendment 2—On page 1, line 1, strike the entire title and insert: A bill to be entitled An act relating to health care; revising provisions relating to health maintenance organizations; amending s. 641.48, F.S.; revising quality of care and financial insolvency provisions for certain exempt prepaid health plans; amending s. 641.495, F.S., relating to exemption of health maintenance organizations with 10 or fewer holding beds from pt. I of ch. 395, F.S.; amending s. 641.51, F.S.; deleting requirement for certain periodic review by an external review organization; broadening scope of second medical opinions available to subscribers; creating s. 641.511, F.S.; providing subscriber grievance reporting requirements and resolution procedures; creating s. 641.512, F.S.; providing for accreditation and an external quality assurance assessment; providing requirements; providing for payment of expenses; amending s. 641.515, F.S.; providing for subsequent department investigations pursuant to ss. 641.311, 641.511, and 641.512, F.S.; providing for standards of care; amending s. 641.52, F.S.; providing an additional condition that may result in suspension of enrollment authority, revocation of certificate, or an order of compliance; providing for a study on provider contracts; rescheduling Sunset review and repeal of pt. IV of ch. 641, F.S.; providing effective dates; providing for a Florida Health Care Commission; revising and transferring various sections of statutes to place health care planning, regulation, and policy development under the commission; amending s. 20.19, F.S.; eliminating the Assistant Secretary for Regulation and Health Facilities of the Department of Health and Rehabilitative Services; transferring functions and duties to the commission; amending s. 381.0612, F.S.; providing duties of the commission regarding the State Center for Health Statistics; transferring the center from the department to the commission; amending s. 381.609, F.S.; providing commission duties regarding a prohibition against HIV testing; transferring ss. 381.701-381.7155, F.S., to pt. II of ch. 408, F.S.; transferring provisions relating to certificates of need and state health planning from the Department of Health and Rehabilitative Services to the commission; amending s. 381.709, F.S.; revising the certificate-of-need review process; amending s. 381.7155, F.S.; providing for enforcement of rules; providing a saving clause for certificates of need currently in effect; amending s. 395.017, F.S.; providing for disclosure of patient records to the commission; amending s. 395.041, F.S.; providing commission duties relating to internal risk management programs; amending ss. 400.304 and 400.307, F.S., relating to operation of the state and district long-term care facility ombudsman councils; amending ss. 400.401 and 400.408, F.S.; providing

commission responsibilities relating to adult congregate living facilities; amending s. 400.623, F.S., relating to recruitment of adult foster homes; creating pt. I of ch. 408, F.S.; creating the Health Care Commission; providing for a comprehensive health plan; providing goals for health care cost containment, access, quality, and planning; providing for location within, but independence from, the Department of Health and Rehabilitative Services; providing for appointment of commissioners; requiring an administrative plan; providing for commission proceedings; providing for a chairman, an executive director, a general counsel, and staff; establishing organizational structure; providing for administrative divisions and bureaus; specifying qualifications, standards for conduct and ex parte communications, and an oath of office for commissioners; providing for commission expenditures, personnel, recordkeeping, and fees for copies of records; restricting certain representation by former commissioners; providing duties of the Public Counsel; creating a trust fund and providing for the use of moneys therein; providing for inquiries and providing an exemption from public records law; providing for review and repeal; providing penalties; providing for rules; authorizing contracts; providing for judicial review; creating the Medical Advisory Panel; providing membership; providing duties; creating the Health Care Work Group; providing membership; requiring a report; repealing ss. 407.01 and 407.04(4), F.S., relating to creation and budget requests of the Health Care Cost Containment Board; transferring the remainder of ch. 407, F.S., to pt. III of ch. 408, F.S.; transferring powers, duties, and operations of the board to the commission; amending s. 624.215, F.S.; requiring reports to the commission of legislative proposals mandating health insurance coverage; directing that changes in terminology in the Florida Statutes be made, relating to the commission's jurisdiction over nursing homes, adult congregate living facilities, home health agencies, adult day care centers, hospitals, and adult foster homes, in ch. 400, F.S.; and health testing services, in ch. 483, F.S.; and in specified sections of the Florida Statutes, to conform to the act; directing that a reviser's bill be prepared to correct cross references and other inconsistencies; providing for Sunset review and repeal of pt. I of ch. 408, F.S., relating to creation of the Health Care Commission; providing for Sundown review and repeal of the Medical Advisory Panel; providing for Sunset review and repeal of pt. II of ch. 408, F.S., relating to certificates of need; rescheduling review and repeal of provisions affected by the act; providing an appropriation; providing effective dates; revising provisions relating to the state Medicaid program; creating s. 409.901, F.S.; providing definitions; creating s. 409.902, F.S.; designating the Department of Health and Rehabilitative Services as the single state agency for administration of the Medicaid program; creating ss. 409.903 and 409.904, F.S.; specifying those persons who may be eligible for the Medicaid program; creating ss. 409.905 and 409.906, F.S.; providing for a federal waiver for certain Medicaid psychiatric services; enumerating federally mandated and optional services covered by the Medicaid program; creating s. 409.907, F.S.; establishing provisions for Medicaid provider agreements; creating s. 409.908, F.S.; establishing reimbursement standards for payment under the Medicaid program; renumbering s. 409.2665, F.S., relating to third-party payments on behalf of Medicaid eligible persons; deleting definitions made obsolete by this act; conforming cross references to changes made by this act; making technical, clarifying revisions; deleting certain requirements pertaining to the recovery of third-party resources for Medicaid benefits made payable by check; creating ss. 409.911, 409.9112, and 409.9113, F.S.; providing for disproportionate share programs for hospitals, regional perinatal intensive care centers, and teaching hospitals for purposes of indigent and obstetrical care; creating ss. 409.9114 and 409.9115, F.S.; providing authority of the department to distribute local government funds and to make extraordinary disproportionate share payments; creating s. 409.912, F.S.; authorizing cost-effective purchasing of care, including contracts with prepaid group practices and establishment of waiver programs; requiring contracting entities to maintain a specified level of liquid assets; providing exceptions; creating s. 409.913, F.S.; setting forth criteria for oversight of goods and services to protect the integrity of the Medicaid program and providing authority to take appropriate action; creating s. 409.914, F.S.; authorizing agreements between the department and other entities to further health insurance coverage for citizens of this state; amending s. 409.267, F.S.; requiring county contributions on behalf of certain persons covered by the Medicaid program, including the establishment of limits thereon and methods for collection; creating s. 409.916, F.S.; requiring deposit of pharmaceutical rebates into the General Revenue Fund; amending s. 409.2662, F.S., relating to the Public Medical Assistance Trust Fund; creating s. 409.919, F.S.; authorizing the Department of Health and Rehabilitative Services to adopt rules; creating s. 409.920, F.S.; requiring the Auditor General to conduct a statewide program of Medicaid fraud control and establishing standards and criminal penalties; creating the Task Force on County Contributions to Medicaid; specifying members of the task force; requiring a study of county contributions to the Medicaid program; requiring a report; directing the department to prepare a report on the adequacy of Medicaid reimbursement to pharmacy providers; amending s. 110.123, F.S., to correct a cross reference, relating to the state group insurance program; amending s. 154.011, F.S., to correct a cross reference, relating to primary care services; amending s. 394.4787, F.S., to correct a cross reference, relating to definitions applicable to provision of acute care mental health services; amending s. 395.01465, F.S., to correct a cross reference, relating to emergency care hospitals; amending s. 400.126, F.S., to correct a cross reference, relating to receivership of nursing home facilities; amending s. 400.18, F.S., to correct a cross reference, relating to closing of nursing facilities; amending s. 400.332, F.S., to correct a cross reference, relating to certain funds received by a nursing home for participation in the geriatric outpatient nurse clinic program; amending s. 407.51, F.S., to correct a cross reference, relating to hospital budgets; amending s. 409.2673, F.S., to correct a cross reference, relating to the shared county and state health care program for low-income persons; amending s. 409.345, F.S., to correct a cross reference, relating to public assistance payments as debt of the recipient; amending s. 409.701, F.S., to correct a cross reference, relating to the Florida Small Business Health Access Corporation Act; amending s. 410.036, F.S., to correct a cross reference, relating to eligibility for home care for disabled adults and the elderly; amending s. 624.424, F.S., to correct a cross reference, relating to statements and records of insurers; amending s. 627.736, F.S., to correct a cross reference, relating to personal injury protection benefits; amending s. 631.813, F.S., to correct a cross reference, relating to application of the Florida Health Maintenance Organization Consumer Assistance Plan; amending s. 641.261, F.S., to correct a cross reference, relating to reporting requirements of health maintenance organizations; amending s. 641.31, F.S., to correct a cross reference, relating to health maintenance contracts; amending s. 641.411, F.S., to correct a cross reference, relating to reporting requirements of prepaid health clinics; amending s. 768.73, F.S., to correct a cross reference, relating to punitive damages; amending s. 895.02, F.S.; adding Medicaid provider fraud to the definition of racketeering activity under the Florida RICO (Racketeer Influenced and Corrupt Organization) Act; preserving election of Medicare and Medicaid hospice benefits; saving existing department rules until superseded; repealing s. 21, ch. 89-275, Laws of Florida, ss. 400.23(3), 409.266, 409.2662, 409.2663, 409.2664, 409.267, 409.2671, and 409.268, F.S., relating to the Medicaid program and payments thereunder; providing effective dates; providing legislative intent relating to indigent health care; amending s. 383.14, F.S.; requiring the screening of infants and their families for specified environmental risk factors; requiring the department to ensure that the screening information registry is integrated with the department's automated data systems; providing for rulemaking; providing for developing a risk-assessment instrument; providing for supplying nutrition education and foods to certain individuals; requiring the coordination of s. 383.14(3), F.S., with certain other legal provisions; amending s. 383.011, F.S.; adding duties of the Department of Health and Rehabilitative Services relating to maternal and child health; requiring the department to establish Healthy Start Care Coordination programs in the county public health units; providing for family outreach workers; requiring screening programs for families identified as being at risk; requiring the provision of services under this section to be consistent with other specified legal provisions and plans; amending s. 383.013, F.S.; adding duties of the Department of Health and Rehabilitative Services relating to prenatal care; amending s. 383.215, F.S.; providing for developmental intervention at hospitals with level II neonatal intensive care units; creating s. 383.216, F.S.; providing for the establishment of prenatal and infant health care coalitions, including establishment and incorporation of local prenatal and infant health care coalitions, and providing for membership, duties, and services; providing for cooperation and assistance from the Department of Health and Rehabilitative Services, and for contribution match percentages; creating s. 383.2161, F.S.; requiring the department annually to compile and analyze risk information and submit a report to the Legislature; providing requirements for the contents of the report; requiring the department to develop and submit to the Legislature a plan for decategorizing certain resources which includes an alternative reimbursement methodology for providers of certain services; amending s. 427.012, F.S.; adding a representative of maternal and child health care providers to the Transportation Disadvantaged Commission; providing effective dates; creating s. 766.1115, F.S.; creating the "Access to Health Care Act of 1991"; authorizing agreements by governmental contractors with health care providers selected and contracted with for the provision of health care services as agent of the governmental contractor; providing an exception; providing

definitions; requiring contracts of agency and specifying terms thereof; providing for access to patient records by governmental contractors and exempting from the public records law patient records, adverse incident reports, and patient treatment outcome information obtained by governmental contractors; providing for future legislative review of this exemption pursuant to the Open Government Sunset Review Act; requiring governmental contractors to establish quality assurance programs; providing for right of control by the governmental contractor; requiring compensated providers to elect under such contracts either a percentage reduction in compensation or a percentage of care to be uncompensated; requiring the establishment of governmental contractor claims funds and excess claims funds; requiring adverse incident and treatment outcome reporting; requiring certain notice; providing for rulemaking; requiring a patient health care treatment and access evaluation methodology and reporting; providing for review and repeal; amending s. 768.28, F.S.; expanding agency to include providers of health care services pursuant to agency agreements with governmental contractors, and reenacting ss. 766.203(1) and 766.207(1), F.S., relating to presuit investigation and voluntary binding arbitration of medical negligence claims, to incorporate said amendment in references thereto; amending s. 766.102, F.S.; providing a definition of health care provider for purposes of medical negligence actions; increasing fees for certain abortion clinics, ambulatory surgical centers, birthing centers, clinical laboratories except community nonprofit blood banks, home health agencies, hospices, intermediate care facilities for the mentally retarded, multiphasic testing centers, health maintenance organizations, and prepaid health clinics to fund state and local health planning; providing for distribution of health care facilities assessments and certificate-of-need application fees among the Statewide Health Council, local health councils, and the Department of Health and Rehabilitative Services; amending s. 381.708, F.S.; increasing application fees for certificates of need; amending s. 390.014, F.S.; increasing licensure fees for abortion clinics; amending s. 395.004, F.S.; increasing licensure fees for hospitals, cardiac catheterization facilities, and ambulatory surgical centers; amending s. 395.007, F.S.; increasing fees for plans and construction review for hospitals, and ambulatory surgical centers; Services access to patient records for complaint investigations; amending s. 400.062, F.S.; increasing nursing home licensure fees; amending s. 400.23, F.S.; increasing fees for plans and construction review for nursing homes; amending s. 400.407, F.S.; increasing adult congregate living facility licensure fees; amending s. 400.418, F.S.; revising a trust fund for deposit of fees and fines; amending s. 400.467, F.S.; increasing home health agency licensure fees; amending s. 400.605, F.S.; increasing hospice licensure fees; amending s. 483.172, F.S.; increasing clinical laboratory licensure fees; creating s. 627.4106, F.S.; providing requirements, restrictions, and renewal and rating provisions that apply to health insurance coverage of certain groups; providing that the Department of Insurance may by rule limit certain rate increases; providing definitions; amending ss. 627.6693, F.S.; revising benefits for small group basic health insurance policies; providing effective dates.

Senator Malchon moved the following amendments which were adopted:

Senate Amendment 1 to House Amendment 1—On page 1, line 10, strike everything after the instruction and insert:

Section 1. Section 395.1015, Florida Statutes, is created to read:

395.1015 Annual assessment on health care entities.—

(1) For purposes of this section, the term:

(a) "Board" means the Health Care Cost Containment Board.

(b) "Net operating revenue" means gross revenue less deductions from revenue.

(c) "Gross revenue" means the sum of daily service charges, ambulatory service charges, ancillary service charges, and other operating revenue.

(d) "Deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

(2) There is imposed an annual assessment against certain health care entities as described in this section:

(a) The assessment shall be equal to 1.5 percent of the annual net operating revenues of health care entities.

1. The first assessment shall be due on April 30, 1992, and the second on April 30, 1993, and each shall be based on the appropriate reports filed with the board no later than March 31 of the year the assessment is due. By January 1, 1992, the health care entity shall make a one-time election to base the assessments on net operating revenue received in the health care entity's latest fiscal year ending on or before December 31, 1991, or December 31, 1992, respectively, or the 12-month period ending March 31 of the year the assessment is due. The assessment shall be payable to and collected by the board.

2. Beginning July 1, 1993, assessments shall be based on annual net operating revenues for the entity's most recently completed fiscal year as provided in subsection (3).

(b) For the purpose of this section, "health care entities" includes the following:

1. Ambulatory surgical centers licensed under s. 395.003.

2. Clinical laboratories licensed under s. 483.091, but does not include any hospital laboratory defined under s. 483.041(7) or any clinical laboratory operated by the state or a political subdivision of the state.

3. Freestanding radiation therapy centers operating primarily for the treatment, not the diagnosis, of a disease and containing equipment licensed under s. 404.22, and sections 10D-99.902, 10D-99.903, and 10D-99.904 of the Florida Administrative Code.

4. Diagnostic imaging centers which are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services such as computed tomography scans and magnetic resonance imaging, and in which services are rendered by a physician licensed by the Board of Medicine under s. 458.311, s. 458.313, or s. 458.317, or by an osteopathic physician licensed by the Board of Osteopathic Medical Examiners under s. 459.006, s. 459.007, or s. 459.0075.

(3)(a) Beginning July 1, 1993, the assessment shall be on the actual experience of the entity as reported to the board within 120 days after the end of its fiscal year in the preceding calendar year based upon reports developed by the board in a rule after consultation with appropriate professional and governmental advisory bodies.

(b) Within 6 months after the end of each entity's fiscal year, the board shall certify to the department the amount of the assessment for each entity. The assessment shall be payable to and collected by the department in equal quarterly amounts, on or before the first day of each calendar quarter, beginning with the first full calendar quarter.

(4) All moneys collected pursuant to this section shall be deposited into the Public Medical Assistance Trust Fund.

(5) The board may use its authority under ss. 407.02, 407.06, and 407.07 in administering this section.

Section 2. Paragraph (a) of subsection (11) of section 407.50, Florida Statutes, is amended to read:

407.50 Review of hospital budgets.—

(11) Notwithstanding any other provisions of this part:

(a) Any hospital operated by the Department of Health and Rehabilitative Services or the Department of Corrections, any comprehensive rehabilitative hospital as defined in s. 407.002(7), any rural hospital as defined in s. 407.002(24), *any intensive residential treatment program for children and adolescents as defined in s. 395.002 and licensed pursuant to chapter 395,* and the Florida Elks Children's Hospital located in Umatilla shall be exempt from filing a budget, shall be exempt from budget review and approval for exceeding the maximum allowable rate of increase, and shall be exempt from any penalties arising therefrom. However, each such hospital shall be required to submit to the board its audited actual experience, as required by s. 407.05(7).

Section 3. Section 409.901, Florida Statutes, is created to read:

409.901 Definitions.—As used in ss. 409.901-409.920, the term:

(1) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under ss. 409.903-409.906 has

been submitted to the department, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.

(2) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, goods, or services.

(3) "Claim" means any communication, whether oral, written, or electronic (electronic impulse or magnetic), which is used by any person to apply for payment from the Florida Medicaid Program or its fiscal agent for each item or service purported by any person to have been provided by a person to any Medicaid recipient.

(4) "Collateral" means:

(a) Any and all causes of action, suits, claims, counterclaims, and demands which accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care, goods, or services which necessitated that Medicaid provide medical assistance.

(b) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(c) Proceeds, as defined in this section.

(5) "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.

(6) "Department" means the Department of Health and Rehabilitative Services. The department is the Medicaid agency for the state, as provided under federal law.

(7) "Florida Medicaid Program" means the program authorized under Title XIX of the federal Social Security Act that provides for payments for medical items or services, or both, on behalf of any person who is determined by the department to be eligible on the date of service for Medicaid assistance.

(8) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.

(9) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in this state by the department.

(10) "Medicaid agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

(11) "Medicaid provider" or "provider" means a person or entity that has a Medicaid provider agreement in effect with the department and is in good standing with the department.

(12) "Medicaid provider agreement" or "provider agreement" means a contract between the department and a provider for the provision of services or goods, or both, to Medicaid recipients pursuant to Medicaid.

(13) "Medicaid recipient" or "recipient" means an individual whom the department determines is eligible, pursuant to federal and state law, to receive medical assistance and related services for which the department may make payments under the Florida Medicaid Program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Florida Medicaid Program, or an individual on whose behalf Medicaid has become obligated.

(14) "Medicaid-related records" means records that relate to the provider's business or profession and to a Medicaid recipient. Medicaid-related records include records related to non-Medicaid customers, clients, or patients but only to the extent that the documentation is shown by the department to be necessary to determine a provider's entitlement to payments under the Florida Medicaid Program.

(15) "Medical assistance" means any provision of, payment for, or liability for medical services by Medicaid to, or on behalf of, any recipient.

(16) "Medical services" or "medical care" means medical or medically related institutional or noninstitutional care, goods, or services covered by the Florida Medicaid Program. The term includes, without limitation, physician services, inpatient hospital services, outpatient hospital services, independent laboratory services, X-ray services, and prescribed drug services, and such other services as are covered by the Florida Medicaid Program.

(17) "Payment," as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. To "pay" means to do any of the acts set forth in this subsection.

(18) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "noncash proceeds."

(19) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.

(20) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the department, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance, or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 4. Section 409.902, Florida Statutes, is created to read:

409.902 Designated single state agency; payment requirements; program title.—The Department of Health and Rehabilitative Services is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments must be made only for services included in the program, must be made only on behalf of eligible individuals, and must be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and state law. This program of medical assistance is designated the "Florida Medicaid Program."

Section 5. Section 409.903, Florida Statutes, is created to read:

409.903 Mandatory payments for eligible persons.—The department shall make payments for medical assistance and related services on behalf of the following individuals whom the department determines are eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law, the availability of moneys, and any limitation established by the General Appropriations Act or chapter 216:

(1) Persons who receive payments from, or are determined eligible for, the federal and state program known as Aid to Families with Dependent Children (AFDC), and certain persons who were eligible for that program but who became ineligible or who would be eligible but do not meet certain technical requirements. This group includes, but is not limited to:

(a) Low-income, single-parent families and their children;

(b) Low-income, two-parent families in which at least one parent is disabled or otherwise incapacitated; and

(c) Certain unemployed two-parent families and their children.

(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI), including a low-income person age 65 or older and a low-income person under age 65 considered to be permanently and totally disabled.

(3) A child under age 21 living in a low-income, two-parent family, and a child under age 7 living with a nonrelative, if the income and assets of the family or child, as applicable, do not exceed the cash-assistance limits under the Aid to Families with Dependent Children program.

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption.

(5) A woman, for the duration of her pregnancy and for a postpartum period as defined in federal rules, or a child under age 1 if either the woman or child lives in a family having an income that is at or below 170 percent of the federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Florida Medicaid Program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Florida Medicaid Program.

(6) A child born after September 30, 1983, living in a family that has an income which is at or below 100 percent of the current federal poverty level who has attained 6 years of age but has not attained the age of 19. In determining the eligibility of such a child, an assets test is not required.

(7) A child living in a family that has an income which is at or below 133 percent of the current federal poverty level who has attained the age of 1 but has not attained the age of 6. In determining the eligibility of such a child, an assets test is not required.

(8) A person who is age 65 or older or is determined by the department to be disabled, who is eligible for the Medicare program, whose income is at or below 100 percent of the federal poverty level, and whose assets do not exceed limitations established by the department. However, the department may only pay for premiums, coinsurance, and deductibles as required by federal law, unless additional coverage is provided under s. 409.904(1).

Section 6. Section 409.904, Florida Statutes, is created to read:

409.904 Optional payments for eligible persons.—The department may make payments for medical assistance and related services on behalf of the following individuals whom the department determines eligible, subject to income, assets, and categorical eligibility tests set forth in federal and state law, the availability of moneys, and any limitation established by the General Appropriations Act or chapter 216:

(1) A person who is age 65 or older or is determined by the department to be disabled, whose income is at or below 100 percent of the federal poverty level, and whose assets do not exceed limitations established by the department.

(2) A person who is in need of the services of a licensed nursing facility, a licensed intermediate care facility for the mentally retarded, or a state mental hospital, whose income does not exceed 300 percent of the Supplemental Security Income (SSI) standard, and who meets the assets standards established under federal and state law.

(3) A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency medical services. The eligibility of such a recipient is limited to the period of the emergency, in accordance with federal regulations.

Section 7. Section 409.905, Florida Statutes, is created to read:

409.905 Mandatory Medicaid services.—The department may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the department to be eligible on the dates on which the services were provided. Any service that is under this section may be provided only when medically necessary, must be provided in accordance with state and federal law, and is subject to the availability of moneys and any limitation established by the General Appropriations Act or chapter 216.

(1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The department shall pay for services provided to a recipient by a licensed advanced registered nurse practitioner who has a valid collaboration agreement with a licensed physician on file with the Department of Professional Regulation or who provides anesthesia services in accordance with the established protocol required by state law and approved by the medical staff of the facility in which the anesthesia service is performed. Reimbursement for such services must be provided in an amount that equals not less than 80 percent of the fee paid for a physician to provide the same service.

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The department shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the department to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

(3) FAMILY PLANNING SERVICES.—The department shall pay for services necessary to enable a recipient to voluntarily plan family size or to space children. These services include information, education, drugs and supplies, and necessary medical care and followup. Each recipient participating in the family planning portion of the Florida Medicaid Program must be provided freedom to choose any alternative method of family planning, as required by federal law.

(4) HOME HEALTH CARE SERVICES.—The department shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection must be licensed under part III of chapter 400 or part I of chapter 499, if appropriate. These services, equipment, and supplies may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(5) HOSPITAL INPATIENT SERVICES.—The department shall pay for all services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395, except that payment for such care and treatment is limited to 45 days per state fiscal year per recipient, with the exception of a Medicaid recipient under age 21 in which case the only limitation is medical necessity. A licensed hospital maintained primarily for the care and treatment of patients having mental disorders or mental diseases is not eligible to participate in the hospital inpatient portion of the Florida Medicaid Program in accordance with federal law, *except the department shall apply for a waiver, within three months of the effective date of this act, designed to provide hospitalization services for mental health reasons to children and adults in the most cost effective and lowest cost settings possible. Such waiver shall include a request for the opportunity to pay for care in hospitals known under federal law as "institutions for mental disease" or "IMDs". The waiver proposal shall propose no additional aggregate cost to the state or federal government, and shall be conducted in District 6 of the Department of Health and Rehabilitative Services. The waiver proposal may incorporate competitive bidding for hospital services, comprehensive brokering, prepaid capitated arrangements, or other mechanisms deemed by the department to show promise in reducing the cost of acute care and increasing the effectiveness of preventive care. When developing the waiver proposal, the department shall take into account price, quality, accessibility, linkages of the hospital to community services and family support programs, plans of the hospital to insure the earliest discharge possible, and the comprehensiveness of the mental health and other health care services offered by participating providers. The Department of Health and Rehabilitative Services is directed to monitor and evaluate the implementation of this waiver program if it is granted and report to the chairmen of the Appropriations Committees by February 1, 1992.*

(6) HOSPITAL OUTPATIENT SERVICES.—The department shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395 and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to $1,000 per state fiscal year per recipient, unless an exception has been made by the department, and with the exception of a Medicaid recipient under age 21 in which case the only limitation is medical necessity.

(7) INDEPENDENT LABORATORY SERVICES.—The department shall pay for medically necessary diagnostic laboratory procedures ordered by a licensed physician or other licensed practitioner of the healing arts which are provided for a recipient in a laboratory that meets the requirements for Medicare participation and, if required, is licensed under chapter 483.

(8) NURSING FACILITY SERVICES.—The department shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part I of chapter 400 which are ordered by and provided under the direction of a licensed physician.

(9) PHYSICIAN SERVICES.—The department shall pay for services and procedures rendered to a recipient by, or under the personal supervision of, a person licensed under state law to practice medicine or osteopathy. These services may be furnished in the physician's office, the Medicaid recipient's home, a hospital, nursing facility, or elsewhere but must be medically necessary for the treatment of an injury, illness, or disease within the scope of the practice of medicine or osteopathy as defined by state law. The department may not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

(10) PORTABLE X-RAY SERVICES.—The department shall pay for professional and technical portable radiological services ordered by a licensed physician or other licensed practitioner of the healing arts which are provided by a licensed professional in a setting other than a hospital, clinic, or office of a physician or practitioner of the healing arts, on behalf of a recipient.

(11) RURAL HEALTH CLINIC SERVICES.—The department shall pay for outpatient primary health care services for a recipient provided by a clinic certified by and participating in the Medicare program which is located in a federally designated, rural, medically underserved area and has on its staff one or more licensed primary care nurse practitioners or physician assistants and a licensed supervising physician.

(12) TRANSPORTATION SERVICES.—The department shall ensure that transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for necessary and Medicaid-compensable services. The department may pay for transportation and other related travel expenses as necessary if these services are not otherwise available.

Section 8. Section 409.906, Florida Statutes, is created to read:

409.906 Optional Medicaid services.—The department may make payments for the following services, which are optional to the state under Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the department to be eligible on the dates on which the services were provided. Any service that is provided under this section may be provided only when medically necessary, must be provided in accordance with state and federal law, and is subject to any limitation established by the General Appropriations Act or chapter 216.

(1) ADULT DENTURE SERVICES.—The department may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older.

(2) ADULT HEALTH SCREENING SERVICES.—The department may pay for an annual routine physical examination, conducted by or under the direction of a licensed physician, for a recipient age 21 or older, without regard to medical necessity, in order to detect and prevent disease, disability, or other health condition or its progression.

(3) AMBULATORY SURGICAL CENTER SERVICES.—The department may pay for services provided to a recipient in an ambulatory surgical center licensed under part I of chapter 395 by or under the direction of a licensed physician or dentist.

(4) BIRTH CENTER SERVICES.—The department may pay for examinations, delivery, recovery and newborn assessment, and related services provided in a licensed birth center staffed with licensed physicians, certified nurse midwives, and midwives licensed in accordance with chapter 467 to a recipient expected to experience a low-risk pregnancy and delivery.

(5) CASE MANAGEMENT SERVICES.—The department may pay for primary care case management services rendered to a recipient pursuant to a federally approved waiver, and targeted case management services for specific groups of targeted recipients, which services are rendered pursuant to federal guidelines.

(6) CHILDREN'S DENTAL SERVICES.—The department may pay for diagnostic, preventive, or corrective procedures, including orthodontia in a severe case, provided to a recipient under age 21 by or under the supervision of a licensed dentist. Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual.

(7) CHIROPRACTIC SERVICES.—The department may pay for manual manipulation of the spine and initial services, screening, and X rays provided to a recipient by a licensed chiropractic physician.

(8) COMMUNITY MENTAL HEALTH SERVICES.—The department may pay for rehabilitative services provided to a recipient in a mental health, drug abuse, or alcohol abuse center licensed by and under contract to the department which are psychiatric in nature and rendered or recommended by a psychiatrist or which are medical in nature and rendered or recommended by a physician or psychiatrist.

(9) DURABLE MEDICAL EQUIPMENT.—The department may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary.

(10) HEARING SERVICES.—The department may pay for hearing and related services, including hearing evaluations, hearing aid devices, dispensing of the hearing aid, and related repairs, if provided to a recipient by a licensed hearing aid specialist, otolaryngologist, otologist, audiologist, or physician.

(11) HOME AND COMMUNITY-BASED SERVICES.—The department may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program.

(12) HOSPICE CARE SERVICES.—The department may pay for all reasonable and necessary services for the palliation or management of a recipient's terminal illness, if the services are provided by a hospice that is licensed under the provisions of part V of chapter 400 and meets Medicare certification requirements.

(13) INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES.—The department may pay for health-related care and services provided on a 24-hour-a-day basis by a facility licensed under chapter 393 to a recipient who needs such care because of his mental or physical condition.

(14) INTERMEDIATE CARE SERVICES.—The department may pay for 24-hour-a-day intermediate care nursing and rehabilitation services rendered to a recipient in a nursing facility licensed under part I of chapter 400, if the services are ordered by and provided under the direction of a physician.

(15) OPTOMETRIC SERVICES.—The department may pay for services provided to a recipient, including examination, diagnosis, treatment, and management, related to ocular pathology, if the services are provided by a licensed optometrist or physician.

(16) PODIATRIC SERVICES.—The department may pay for services, including diagnosis, medical, surgical, palliative, and mechanical treatment, related to ailments of the human foot and lower leg, if provided to a recipient by a podiatrist licensed under state law.

(17) PRESCRIBED DRUG SERVICES.—The department may pay for medications that are prescribed for a recipient by a physician or other licensed practitioner of the healing arts authorized to prescribe medications and that are dispensed to the recipient by a licensed pharmacist or physician in accordance with applicable state and federal law.

(18) STATE HOSPITAL SERVICES.—The department may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state mental hospital.

(19) VISUAL SERVICES.—The department may pay for visual examinations, eyeglasses, and eyeglass repairs for a recipient if they are prescribed by a licensed physician specializing in diseases of the eye or by a licensed optometrist.

Section 9. Section 409.907, Florida Statutes, is created to read:

409.907 Requirements for Medicaid provider agreements.—The department may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has

a provider agreement in effect with the department, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the department.

(1) Each provider agreement must require the provider to comply fully with all state and federal laws pertaining to the Florida Medicaid Program, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts, and must require the provider to provide services or goods of not less than the scope and quality as it provides to the general public.

(2) Each provider agreement must be a voluntary contract between the department and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Florida Medicaid Program when furnishing a service or goods to a Medicaid recipient and the department agrees to pay a sum, determined by fee schedule, payment methodology, or other manner, for the service or goods provided to the Medicaid recipient. Each provider agreement must be effective for a stipulated period of time, must be terminable by either party after reasonable notice, and must be renewable by mutual agreement.

(3) The provider agreement developed by the department, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(a) Have in his possession at the time of signing the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional or facility license pertinent to the services or goods being provided, if required by the state or locality in which the provider is located, and the Federal Government, if applicable.

(b) Maintain in a systematic and orderly manner all medical and Medicaid-related records as the department may require and as it determines necessary for the services or goods being provided.

(c) Retain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the department.

(d) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

(e) Permit the department, the Auditor General, the Federal Government, and the authorized agents of each of these entities access to all Medicaid-related information which may be in the form of records, logs, documents, computer files, and other information pertaining to services or goods billed to the Florida Medicaid Program, including access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records, or if necessary for the conduct of an investigation or audit.

(f) Bill other insurers and third parties, including the Medicare program, before billing the Florida Medicaid Program if the recipient is eligible for payment for health care or related services from another insurer or person and comply with all other state and federal requirements in this regard.

(g) Promptly report any moneys received in error or in excess of the amount to which the provider is entitled from the Florida Medicaid Program and promptly refund such moneys to the department.

(h) Be liable for and indemnify, defend, and hold the department harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient.

(i) At the option of the department, provide proof of liability insurance and maintain such insurance in effect for any period during which services or goods are furnished to Medicaid recipients.

(j) Accept Medicaid payment as payment in full, and prohibit the provider from billing or collecting from the recipient or the recipient's responsible party any additional amount except, and only to the extent the department permits or requires, copayments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided. The Medicaid payment-in-full policy does not apply to services or goods provided to a recipient if the services or goods are not covered by the Medicare program.

(4) A provider agreement must provide that, if the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the department Medicaid-related records that relate to the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

(5) The department:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form must require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the department, the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

(b) Is prohibited from demanding repayment from the provider in any instance in which the Medicaid overpayment is attributable to departmental error in the determination of eligibility of a recipient.

(c) May adopt, and include in the provider agreement, such other requirements and stipulations on either party as the department finds necessary to properly and efficiently administer the Florida Medicaid Program.

(6) A Medicaid provider agreement may be revoked, at the option of the department, as the result of a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement. A provider must give the department 60 days' notice before making any change in ownership of the entity named in the provider agreement as the provider.

(7) The department may require, as a condition of participating in the Florida Medicaid Program and before entering into the provider agreement, that the provider submit information concerning the professional, business, and personal background of the provider. If the provider is a corporation, partnership, association, or other entity, the department may require the provider to submit information concerning the background of that entity and of any principal of the entity, including any partner or shareholder having an ownership interest in the entity equal to 5 percent or greater.

(8) Before signing a provider agreement, the department shall require the provider to submit:

(a) Proof of holding a valid license or operating certificate, as applicable, if required by the state or local jurisdiction in which the provider is located or if required by the Federal Government.

(b) Information concerning any prior violation, fine, suspension, termination, or other administrative action taken under the Medicaid laws, rules, or regulations of this state or of any other state or the Federal Government; any prior violation of the laws, rules, or regulations relating to the Medicare program; any prior violation of the rules or regulations of any other public or private insurer; and any prior violation of the laws, rules, or regulations of any regulatory body of this or any other state. The information required is that which pertains to the entity entering into the provider agreement with the department; to any principal, partner, or shareholder having an ownership interest in the entity of 5 percent or greater; and to any treating provider who participates or intends to participate in Medicaid through the entity acting as a group provider.

(c) Notice of, and copies of court documents not sealed by the court of jurisdiction, related to any criminal charge brought in any court in the United States against the provider or the provider entity, or any principal, partner, or major shareholder thereof.

(d) Full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health-care-related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(e) If a group provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the Florida Medicaid Program.

(9) All statements and information furnished by the prospective provider for background information before signing the provider agreement must be true and complete. The filing of materially incomplete or false information is sufficient cause for immediate termination of the provider from the Florida Medicaid Program.

(10) Before signing a provider agreement and at the discretion of the department, other provisions of this section notwithstanding, an entity may become eligible to receive payment from the Florida Medicaid Program at the time it first furnishes services or goods if:

(a) The services or goods provided are otherwise compensable;

(b) The entity meets all other requirements of a Medicaid provider at the time the services or goods were provided; and

(c) The entity agrees to abide by the provisions of the provider agreement effective from the date the services or goods were provided.

(11) A provider may not reenroll in the Florida Medicaid Program once suspended or terminated if any fine or overpayment properly assessed has not been repaid, unless the department has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

(12) A provider who fails to adhere to an agreed-upon repayment schedule, whether or not he has previously been suspended or terminated, may be terminated by the department for nonpayment or partial payment.

Section 10. Section 409.908, Florida Statutes, is created to read:

409.908 Reimbursement of Medicaid providers.—The department shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the department and in policy manuals and handbooks incorporated by reference in rules of the department. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, and other mechanisms the department considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid-compensable services made on behalf of an eligible Medicaid recipient is subject to the availability of moneys and any limitation established by the General Appropriations Act or chapter 216.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited to 45 days per state fiscal year per recipient, except for children under age 21, in which case the only limitation is medical necessity or the payment amount. Reimbursement for hospital outpatient care is limited to $1,000 per state fiscal year per recipient, unless an exception has been made by the department, and with the exception of children under age 21, in which case the only exception is medical necessity.

(b) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients or that participate in the Regional Perinatal Intensive Care Center program under chapter 383 must receive additional reimbursement. The total amount of payment for disproportionate-share hospitals must be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the methodology described in s. 409.917.

(2) Reimbursement to nursing homes licensed under part I of chapter 400 and intermediate care facilities for the mentally retarded licensed under part I of chapter 393 must be made prospectively. Reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment.

(3) The following Medicaid services and goods must be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment must be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the department, whichever amount is less, with the exception of those services or goods for which the department makes payment using a methodology based on average costs or negotiated fees.

(a) Advanced registered nurse practitioner services.

(b) Birth center services.

(c) Chiropractic services.

(d) Community mental health services.

(e) Dental services, including oral and maxillofacial surgery.

(f) Durable medical equipment.

(g) Hearing services.

(h) Occupational therapy for Medicaid recipients under age 21.

(i) Optometric services.

(j) Orthodontic services.

(k) Personal care for Medicaid recipients under age 21.

(l) Physical therapy for Medicaid recipients under age 21.

(m) Podiatric services.

(n) Portable X-ray services.

(o) Private duty nursing for Medicaid recipients under age 21.

(p) Respiratory therapy for Medicaid recipients under age 21.

(q) Speech therapy for Medicaid recipients under age 21.

(r) Visual services.

(4) Alternative health plans, health maintenance organizations, and prepaid health plans must be reimbursed a fixed, prepaid amount negotiated by the department and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the department determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility.

(5) An ambulatory surgical center must be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 must be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the department. A provider of the visual, dental, and hearing components of such services must be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the department.

(7) A provider of family planning services must be reimbursed the lesser of the amount billed by the provider or an all-inclusive amount per type of visit for physicians and advanced registered nurse practitioners as established by the department in a fee schedule.

(8) A provider of home-based or community-based services rendered pursuant to a federally approved waiver must be reimbursed based on an established or negotiated rate for each service. These rates must be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver program, or under any other methodology adopted by the department and approved by the Federal Government in accordance with the waiver.

(9) A provider of home health care services, medical supplies, and appliances must be reimbursed the lesser of the amount billed by the provider or the department's established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the department's established maximum allowable amount, whichever amount is less.

(10) A provider of hospice care services must be reimbursed through a prospective-cost-reimbursement system for each Medicaid hospice provider.

(11) A provider of independent laboratory services must be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the department.

(12)(a) A physician must be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the department.

(b) Effective October 1, 1991, the department shall increase fees for surgical and other procedures for which the fees have not been increased since 1987 to the median level of Medicare reimbursement in 1986 for Area B in this state.

(13) Premiums, deductibles, and coinsurance for Medicare services rendered to Medicaid recipients must be reimbursed in accordance with fees established by Title XVIII of the Social Security Act.

(14) A provider of prescribed drugs must be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the department, plus a dispensing fee.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver must be reimbursed by payment of a fixed, prepaid monthly sum for each Medicaid recipient enrolled with the provider.

(16) A provider of rural health clinic services and federally qualified health center services must be reimbursed on a per-visit rate, based on total reasonable costs of the clinic, as determined by the department in accordance with federal regulations.

(17) A provider of targeted case management services must be reimbursed pursuant to an established fee, except where the Federal Government requires that a public provider be reimbursed on the basis of average actual costs.

(18) A provider of transportation services must be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the department, except when the department has entered into a direct contract with the provider for the provision of an all-inclusive service or when services are provided pursuant to an agreement negotiated between the department and the provider.

Section 11. Section 409.909, Florida Statutes, is created to read:

409.909 Additional reimbursement requirements.—A provider of prescription drug services authorized to dispense prescriptions pursuant to chapter 465 shall be reimbursed the wholesale acquisition cost of the drug plus 7 percent, plus a dispensing fee. The dispensing fee paid by the Florida Medicaid Program to pharmacists shall be adjusted to reflect both economies of scale for large volume providers and increased costs for providers of technically complex services. Dispensing costs established in the 1985 Dispensing Cost Survey, conducted by the department, shall be used as a guide to determine lower and upper limits of cost with an adjustment to reflect current knowledge of technically complex pharmacy services. The total cost of dispensing fees paid to pharmacists shall not exceed the total cost that would have been paid using the current fixed fee of $4.23 per prescription for fiscal year 1991-1992.

Section 12. Section 409.2665, Florida Statutes, 1990 Supplement, is transferred, renumbered as section 409.910, Florida Statutes, and amended to read:

409 910 ~~409.2665~~ Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(1) It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien, and subrogation are to be abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources. It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.

(2) This section may be cited as the "Medicaid Third-Party Liability Act."

~~(3) As used in this section, the following words shall have the following meanings:~~

~~(a) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under s. 409.266 has been submitted to the department, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.~~

~~(b) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, good, or service.~~

~~(c) "Collateral" means:~~

~~1. Any and all causes of action, suits, claims, counterclaims, and demands which accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care which necessitated that Medicaid provide medical assistance.~~

~~2. All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.~~

~~3. Proceeds, as defined in this section.~~

~~(d) "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.~~

~~(e) "Department" means the Department of Health and Rehabilitative Services. The department is the Medicaid agency for the state, as provided under federal law.~~

~~(f) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.~~

~~(g) "Lienholder" means the department, which has a lien under paragraph (7)(c).~~

~~(h) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in Florida by the department.~~

~~(i) "Medicaid agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.~~

~~(j) "Medical assistance" means any provision of, payment for, or liability for medical services by Medicaid to, or on behalf of, any recipient.~~

~~(k) "Medical services" or "medical care" means medical or medically related institutional or noninstitutional care, goods, or services covered by the Florida Medicaid program. The term includes, without limitation, physician services, inpatient hospital services, outpatient hospital services, independent laboratory services, X-ray services, and prescribed drug services, and such other services as are covered by the Florida Medicaid program.~~

~~(l) "Payment," as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. To "pay" means to do any of the acts set forth in this paragraph.~~

~~(m) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "noncash proceeds."~~

~~(n) "Provider" means any entity, including, without limitation, any hospital, physician, or other health care practitioner, supplier, or facility, providing medical care and related goods or services to a recipient.~~

~~(o) "Recipient" means any individual who has been determined to be eligible for Medicaid or who is receiving, or has received, medical assistance, or any medical care, good, or service for which Medicaid has paid or may be obligated.~~

~~(p) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.~~

~~(q) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the department, for any Medicaid-covered injury, illness, good, or service, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance, or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.~~

(3)~~(4)~~ Third-party benefits for medical services shall be primary to medical assistance provided by Medicaid.

(4)~~(5)~~ After the department has provided medical assistance under *the Florida Medicaid Program* ~~s. 409.266~~, it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the department has a waiver pursuant to federal law; or

(b) Situations in which the department learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid.

(5)~~(6)~~ An applicant, recipient, or legal representative shall inform the department of any rights the applicant or recipient has to third-party benefits and shall inform the department of the name and address of any person that is or may be liable to provide third-party benefits. When the department provides, pays for, or becomes liable for medical services provided by a hospital, the recipient receiving such medical services or his legal representative shall also provide the information as to third-party benefits, as defined in this section, to the hospital, which shall ~~periodically~~ provide notice thereof to the department in a manner specified by the department.

(6)~~(7)~~ When the department provides, pays for, or becomes liable for medical care under *the Florida Medicaid Program* ~~s. 409.266~~, it *has* ~~shall have~~ the following rights, as to which the department may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits:

(a) The department is automatically subrogated to any rights that an applicant, recipient, or legal representative has to any third-party benefit for the full amount of medical assistance provided by Medicaid. Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the department from any and all third-party benefits. Equities of a recipient, his legal representative, a recipient's creditors, or health care providers shall not defeat, reduce, or prorate recovery by the department as to its subrogation rights granted under this paragraph.

(b) By applying for or accepting medical assistance, an applicant, recipient, or legal representative automatically assigns to the department any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

1. The assignment granted under this paragraph is absolute, and vests legal and equitable title to any such right in the department, but not in excess of the amount of medical assistance provided by the department.

2. The department is a bona fide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person. Equities of a recipient, his legal representative, his creditors, or health care providers shall not defeat or reduce recovery by the department as to the assignment granted under this paragraph.

3. By accepting medical assistance, the recipient grants to the department the limited power of attorney to act in his name, place, and stead to perform specific acts with regard to third-party benefits, his assent being deemed to have been given, including:

a. Endorsing any draft, check, money order, or other negotiable instrument representing third-party benefits that are received on behalf of the recipient as a third-party benefit.

b. Compromising claims to the extent of the rights assigned, provided the recipient is not otherwise represented by an attorney as to the claim.

(c) The department is entitled to, and has, an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable, upon the collateral, as defined in *s. 409.901* ~~this section~~.

1. The lien attaches automatically when a recipient first receives treatment for which the department may be obligated to provide medical assistance under *the Florida Medicaid Program* ~~s. 409.266~~. The lien is perfected automatically at the time of attachment.

2. The department is authorized to file a verified claim of lien. The claim of lien shall be signed by an authorized employee of the *department* ~~lienholder~~, and shall be verified as to the employee's knowledge and belief. The claim of lien may be filed and recorded with the clerk of the circuit court in the recipient's last known county of residence or in any county deemed appropriate by the department. The claim of lien, to the extent known by the department, shall contain:

a. The name and last known address of the person to whom medical care was furnished.

b. The date of injury.

c. The period for which medical assistance was provided.

d. The amount of medical assistance provided or paid, or for which Medicaid is otherwise liable.

e. The names and addresses of all persons claimed by the recipient to be liable for the covered injuries or illness.

3. The filing of the claim of lien pursuant to this section shall be notice thereof to all persons.

4. If the claim of lien is filed within 1 year after the later of the date when the last item of medical care relative to a specific covered injury or illness was paid, or the date of discovery by the department of the liability of any third party, or the date of discovery of a cause of action against a third party brought by a recipient or his legal representative, record notice shall relate back to the time of attachment of the lien.

5. If the claim of lien is filed after 1 year *after* ~~of~~ the later of the events specified in subparagraph 4., notice shall be effective as of the date of filing.

6. Only one claim of lien need be filed to provide notice as set forth in this paragraph and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by Medicaid for any specific covered injury or illness. The department may, in its discretion, file additional, amended, or substitute claims of lien at any time after the initial filing, until the department has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

7. No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the *department* ~~lienholder~~ joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the *department is* ~~lienholder shall be~~ entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the *department* ~~lienholder~~ may recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid. Nothing in this section shall be construed as creating a lien or other obligation on the part of an insurer which in good faith has paid a claim pursuant to its contract without knowledge or actual notice that the department has provided medical assistance for the recipient related to a particular covered injury or illness. However, notice or knowledge that an insured is, or has been a Medicaid recipient within 1 year from the date of service for which a claim is being paid creates a duty to inquire on the part of the insurer as to any injury or illness for which the insurer intends *or is otherwise required* to pay benefits.

8. The lack of a properly filed claim of lien shall not affect the department's assignment or subrogation rights provided in this subsection, nor shall it affect the existence of the lien, but only the effective date of notice as provided in subparagraph 5.

9. The lien created by this paragraph is a first lien and superior to the liens and charges of any provider, and shall exist for a period of 7 years, if recorded, *after* ~~from~~ the date of recording; and shall exist for a period of 7 years *after* ~~from~~ the date of attachment, if not recorded. If recorded, the lien may be extended for one additional period of 7 years by rerecording the claim of lien within the 90-day period preceding the expiration of the lien.

10. The clerk of the circuit court for each county in the state shall endorse on a claim of lien filed under this paragraph the date and hour of filing and shall record the claim of lien in the official records of the county as for other records received for filing. The clerk shall receive as his fee for filing and recording any claim of lien or release of lien under this paragraph the total sum of $2. Any fee required to be paid by the department shall not be required to be paid in advance of filing and recording, but may be billed to the department after filing and recording of the claim of lien or release of lien.

11. After satisfaction of any lien recorded under this paragraph, the department shall, within *60* ~~30~~ days *after* ~~of~~ satisfaction, either file with the appropriate clerk of the circuit court or mail to any appropriate party, or counsel representing such party, if represented, a satisfaction of lien in a form acceptable for filing in Florida.

(7)~~(8)~~ The department shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

(a) Recovery of such benefits shall be collected directly from:

1. Any third party;

2. The recipient or legal representative, if he has received third-party benefits;

3. The provider of a recipient's medical services if third-party benefits have been recovered by the provider; notwithstanding any provision of this section, to the contrary, however, no provider shall be required to refund or pay to the department any amount in excess of the actual third-party benefits received by the provider from a third-party payor for medical services provided to the recipient; or

4. Any person who has received the third-party benefits.

(b) Upon receipt of any recovery or other collection pursuant to this section, the department shall distribute the amount collected as follows:

1. To itself, an amount equal to the state Medicaid expenditures for the recipient plus any incentive payment made in accordance with paragraph *(14)(a)*~~(15)(a)~~.

2. To the Federal Government, the federal share of the state Medicaid expenditures minus any incentive payment made in accordance with paragraph *(14)(a)*~~(15)(a)~~ and federal law, and minus any other amount permitted by federal law to be deducted.

3. To the recipient, after deducting any known amounts owed to the department for any related medical assistance or to health care providers, any remaining amount. This amount shall be treated as income or resources in determining eligibility for Medicaid.

(8)~~(9)~~ The department shall require an applicant or recipient, or the legal representative thereof, to cooperate in the recovery by the department of third-party benefits of a recipient and in establishing paternity and support of a recipient child born out of wedlock. As a minimal standard of cooperation, the recipient or person able to legally assign a recipient's rights shall:

(a) Appear at an office designated by the department to provide relevant information or evidence.

(b) Appear as a witness at a court or other proceeding.

(c) Provide information, or attest to lack of information, under penalty of perjury.

(d) Pay to the department any third-party benefit received.

(e) Take any additional steps to assist in establishing paternity or securing third-party benefits, or both.

(f) Paragraphs (a)-(e) notwithstanding, the department shall have the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

(9)~~(10)~~ The department shall deny or terminate eligibility for any applicant or recipient who refuses to cooperate as required in subsection *(8)*~~(9)~~, unless cooperation has been waived in writing by the department as provided in paragraph *(8)(f)*. ~~(9)(f); provided,~~ However, ~~that~~ any denial or termination of eligibility shall not reduce medical assistance otherwise payable by the department to a provider for medical care provided to a recipient prior to denial or termination of eligibility.

(10)~~(11)~~ An applicant or recipient shall be deemed to have provided to the department the authority to obtain and release medical information and other records with respect to such medical care, for the sole purpose of obtaining reimbursement for medical assistance provided by Medicaid.

(11)~~(12)~~ The department may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal *or administrative* proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(a) If either the recipient, or his legal representative, or the department brings an action against a third party, the recipient, or his legal representative, or the department, or their attorneys, shall, within 30 days *after* ~~of~~ filing the action, provide to the other written notice, by personal delivery or registered mail, of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If an action is brought by either the department, or the recipient or his legal representative, the other may, at any time before trial on the merits, become a party to, or shall consolidate his action with the other if brought independently. Unless waived by the other, the recipient, or his legal representative, or the department shall provide notice to the other of the intent to dismiss at least 21 days prior to voluntary dismissal of an action against a third party. Notice to the department shall be sent to an address set forth by rule. Notice to the recipient or his legal representative, if represented by an attorney, shall be sent to the attorney, and, if not represented, then to the last known address of the recipient or his legal representative.

(b) An action by the department to recover damages in tort under this subsection, which action is derivative of the rights of the recipient or his legal representative, shall not constitute a waiver of sovereign immunity pursuant to s. 768.14.

(c) In the event of judgment, award, or settlement in a claim or action against a third party, the court shall order the segregation of an amount sufficient to repay the department's expenditures for medical assistance, plus any other amounts permitted under this section, and shall order such amounts paid directly to the department.

(d) No judgment, award, or settlement in any action by a recipient or his legal representative to recover damages for injuries or other third-party benefits, when the department has an interest, shall be satisfied without first giving the department notice and a reasonable opportunity to file and satisfy its lien, and satisfy its assignment and subrogation rights or proceed with any action as permitted in this section.

(e) Except as otherwise provided in this section, notwithstanding any other provision of law, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the department's claims for reimbursement of the amount of medical assistance provided and any lien pursuant thereto.

(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his legal representative is a party and in which the amount of any judgment, award, or settlement from third-party benefits, excluding medical coverage as defined in subparagraph 4., after reasonable costs and expenses of litigation, is an amount equal to or less than 200 percent of the amount of medical assistance provided by Medicaid less any medical coverage paid or payable to the department, then distribution of the amount recovered shall be as follows:

1. Any fee for services of an attorney retained by the recipient or his legal representative shall not exceed an amount equal to 25 percent of the recovery, after reasonable costs and expenses of litigation, from the judgment, award, or settlement.

2. After attorney's fees, two-thirds of the remaining recovery shall be designated for past medical care and paid to the department for medical assistance provided by Medicaid.

3. The remaining amount from the recovery shall be paid to the recipient.

4. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

(g) In the event that the recipient, his legal representative, or his estate brings an action against a third party, notice of institution of legal proceedings, notice of settlement, and all other notices required by this section or by rule shall be given to the department, in Tallahassee, in a manner set forth by rule. All such notices shall be given by the attorney retained to assert the recipient's or legal representative's claim, or, if no attorney is retained, by the recipient, his legal representative, or his estate.

(h) Except as otherwise provided in this section, actions to enforce the rights of the department under this section shall be commenced within 5 years *after* ~~of~~ the date a cause of action accrues, with the period running from the later of the date of discovery by the department of a case filed by a recipient or his legal representative, or of discovery of any judgment, award, or settlement contemplated in this section, or of discovery of facts giving rise to a cause of action under this section. Nothing in this paragraph affects or prevents a proceeding to enforce a lien during the existence of the lien as set forth in subparagraph *(6)(c)9.* ~~(7)(c)9.~~

(i) Upon the death of a recipient, and within the time prescribed by ss. 733.702 and 733.710, the department, in addition to any other available remedy, may file a claim against the estate of the recipient for the total amount of medical assistance provided by Medicaid for the benefit of the recipient. Claims so filed shall take priority as class 3 claims as provided by s. 733.707(1)(c). The filing of a claim pursuant to this paragraph shall neither reduce nor diminish the general claims of the department pursuant to s. 409.345, except that the department shall not receive double recovery for the same expenditure. Claims under this paragraph shall be superior to those under s. 409.345. The death of the recipient shall neither extinguish nor diminish any right of the department to recover third-party benefits from a third party or provider. Nothing in this paragraph affects or prevents a proceeding to enforce a lien created pursuant to this section or a proceeding to set aside a fraudulent conveyance as defined in subsection *(16)*~~(17)~~.

(12)~~(13)~~ No action taken by the department shall operate to deny the recipient's recovery of that portion of benefits not assigned or subrogated to the department, or not secured by the department's lien. The department's rights of recovery created by this section, however, shall not be limited to some portion of recovery from a judgment, award, or settlement. Only the following benefits are not subject to the rights of the department: benefits not related in any way to a covered injury or illness; proceeds of life insurance coverage on the recipient; proceeds of insurance coverage, such as coverage for property damage, which by its terms and provisions cannot be construed to cover personal injury, death, or a covered injury or illness; proceeds of disability coverage for lost income; and recovery in excess of the amount of medical benefits provided by Medicaid after repayment in full to the department.

(13)~~(14)~~ No action of the recipient shall prejudice the rights of the department under this section. No settlement, agreement, consent decree, trust agreement, annuity contract, pledge, security arrangement, or any other device, hereafter collectively referred to in this subsection as a "settlement agreement," entered into or consented to by the recipient or his legal representative shall impair the department's rights. Provided, however, that in a structured settlement, no settlement agreement by the parties shall be effective or binding against the department for benefits accrued without the express written consent of the department or an appropriate order of a court having personal jurisdiction over the department.

(14)~~(15)~~ The department is authorized to enter into agreements to enforce or collect medical support and other third-party benefits.

(a) If a cooperative agreement is entered into with any agency, program, or subdivision of the state, or any agency, program, or legal entity of or operated by a subdivision of the state, or with any other state, the department is authorized to make an incentive payment of up to 15 percent of the amount actually collected and reimbursed to the department, to the extent of medical assistance paid by Medicaid. Such incentive payment is to be deducted from the federal share of that amount, to the extent authorized by federal law. The department may pay such person an additional percentage of the amount actually collected and reimbursed to the department as a result of the efforts of the person, but no more than a maximum percentage established by the department. In no case shall the percentage exceed the lesser of a percentage determined to be commercially reasonable or 15 percent, in addition to the 15-percent incentive payment, of the amount actually collected and reimbursed to the department as a result of the efforts of the person under contract.

(b) If an agreement to enforce or collect third-party benefits is entered into by the department with any person other than those described in paragraph (a), including any attorney retained by the department who is not an employee or agent of any person named in paragraph (a), then the department may pay such person a percentage of the amount actually collected and reimbursed to the department as a result of the efforts of the person, to the extent of medical assistance paid by Medicaid. In no case shall the percentage exceed a maximum established by the department, which shall not exceed the lesser of a percentage determined to be commercially reasonable or 30 percent of the amount actually collected and reimbursed to the department as a result of the efforts of the person under contract.

(c) An agreement pursuant to this subsection may permit reasonable litigation costs or expenses to be paid from the department's recovery to a person under contract with the department.

(d) Contingency fees and costs incurred in recovery pursuant to an agreement under this subsection may, for purposes of determining state and federal share, be deemed to be administrative expenses of the state. To the extent permitted by federal law, such administrative expenses shall be shared with, or fully paid by, the Federal Government.

(15)~~(16)~~ Insurance and other third-party benefits may not contain any term or provision which purports to limit or exclude payment or provisions of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance from Medicaid, and any such term or provision shall be void as against public policy.

(16)~~(17)~~ Any transfer or encumbrance of any right, title, or interest to which the department has a right pursuant to this section, with the intent, likelihood, or practical effect of defeating, hindering, or reducing recovery by the department for reimbursement of medical assistance provided by Medicaid, shall be deemed to be a fraudulent conveyance, and such transfer or encumbrance shall be void and of no effect against the claim of the department, unless the transfer was for adequate consideration and the proceeds of the transfer are reimbursed in full to the department, but not in excess of the amount of medical assistance provided by Medicaid.

(17)~~(18)~~ A recipient or his legal representative or any person representing, or acting as agent for, a recipient or his legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph *(6)(c)*~~(7)(c)~~, or who has actual knowledge of the department's rights to third-party benefits under this section, who receives any third-party benefit or proceeds therefrom for a covered illness or injury, is required either to pay the department the full amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid, or to place the full amount of the third-party benefits in a trust account for the benefit of the department pending judicial *or administrative* determination of the department's right thereto. Proof that any such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds therefrom were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that any such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed either to pay the department the full amount required by this section or to hold the full amount of third-party benefits or proceeds in trust pending judicial *or administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 409.325(4)(b), and acted with the intent set forth in s. 812.014(1).*

(a) In cases of suspected criminal violations or fraudulent activity, the department is authorized to take any civil action permitted at law or equity to recover the greatest possible amount, including, without limitation, treble damages under ss. 772.11 and 812.035(7).

(b) The department is authorized to investigate and to request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 409.325 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Auditor General, to the Attorney General, or to any state attorney. Pursuant to *s. 409.913* ~~s. 409.2664~~, the Auditor General has primary responsibility to investigate and control Medicaid fraud.

(c) In carrying out duties and responsibilities related to Medicaid fraud control, the department may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(d) All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft *is* ~~shall be~~ confidential and exempt from the provisions of s. 119.07(1):

1. Until such time as the department takes final agency action;

2. Until such time as the Auditor General refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

~~(19) Entities providing health insurance as defined in s. 624.603, shall, except as otherwise provided in this section, require that any check for third-party benefits be made payable to, and endorsed by, both the insured recipient, or his legal representative, and the provider, to ensure that the provider receives such third-party payment, and, if otherwise required by this section, that the department recovers from the provider. As provided in this section, the department may endorse any check on behalf of a recipient or legal representative as assignee of the recipient. Where the recovery from the insurer has been the subject of a judgment, award, or settlement, or when otherwise necessary to protect the department's rights under this section, the department shall recover directly from a health insurer, which shall require that any check for medical assistance be made payable to the department.~~

(18)~~(20)~~ In recovering any payments in accordance with this section, the department is authorized to make appropriate settlements.

(19)~~(21)~~ Notwithstanding any provision in this section to the contrary, the department shall not be required to seek reimbursement from a liable third party on claims for which the department determines that the amount it reasonably expects to recover will be less than the cost of recovery, or that recovery efforts will otherwise not be cost-effective.

(20)~~(22)~~ Entities providing health insurance as defined in s. 624.603, and health maintenance organizations and prepaid health clinics as defined in chapter 641, shall provide such records and information as are necessary to accomplish the purpose of this section, unless such requirement results in an unreasonable burden.

(a) The secretary of the department and the Insurance Commissioner shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objective of this section.

1. The department shall request only that information necessary to determine whether health insurance as defined pursuant to s. 624.603, or those health services provided pursuant to chapter 641, could be, should be, or have been claimed and paid with respect to items of medical care and services furnished to any person eligible for services under this section.

2. All information obtained pursuant to subparagraph 1. *is* ~~shall be~~ confidential and exempt from ~~the provisions of~~ s. 119.07(1). This exemption *is* ~~shall be~~ subject to the Open Government Sunset Review Act in accordance with s. 119.14.

3. The cooperative agreement or rules *adopted* ~~promulgated~~ under this subsection may include financial arrangements to reimburse the reporting entities for reasonable costs or a portion thereof incurred in furnishing the requested information. Neither the cooperative agreement nor the rules shall require the automation of manual processes to provide the requested information.

(b) The department and the Department of Insurance jointly shall *adopt* ~~promulgate~~ rules for the development and administration of the cooperative agreement. The rules shall include the following:

1. A method for identifying those entities subject to furnishing information under the cooperative agreement.

2. A method for furnishing requested information.

3. Procedures for requesting exemption from the cooperative agreement based on an unreasonable burden to the reporting entity.

(21)~~(23)~~ The department is authorized to adopt rules to implement the provisions of this section and federal requirements.

Section 13. Section 409.911, Florida Statutes, is created to read:

409.911 Cost-effective purchasing of health care.—The department shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The department shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies designed to facilitate the cost-effective purchase of a case-managed continuum of care. The department shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(1) The department may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920.

(2) The department may contract with health maintenance organizations certified pursuant to part II of chapter 641 for the provision of services to recipients.

(3) The department may contract with health units and other entities authorized by chapter 154 to provide health care services on a prepaid per capita or prepaid aggregate fixed-sum basis to recipients, which entities may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services are exempt from part II of chapter 641.

(4) The department may contract with any public or private entity on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of health care services to recipients.

(a) An entity may provide prepaid services to recipients either directly or through arrangements with other entities, if each entity involved in providing services:

1. Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

2. Assures that services meet the standards set by the department for quality, appropriateness, and timeliness;

3. Makes provisions satisfactory to the department for insolvency protection and assures that neither enrolled Medicaid recipients nor the department will be liable for the debts of the entity;

4. Submits to the department, if a private entity, a financial plan that the department finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets, excluding revenues from Medicaid premium payments, equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

5. Furnishes evidence satisfactory to the department of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

6. Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the department; and

7. Provides organizational, operational, financial, and other information required by the department.

(b) Entities that do not provide prepaid health care services other than Medicaid services under contract with the department are exempt from part II of chapter 641.

(5) The department may contract on a prepaid per capita or aggregate fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the department;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is in good standing with the Department of Insurance.

(6) The department may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and to reduce the cost of the Florida Medicaid Program to the state and federal governments. The department shall implement such programs after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(7) The department shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(8) The department shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(9) The department shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

(10) The department shall identify health care utilization and price patterns within the Florida Medicaid Program that are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service and may implement such methods as it considers appropriate.

(11) The department may not contract on a prepaid per capita or prepaid aggregate fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of or entered a plea of nolo contendere to:

(a) Fraud;

(b) Violating a federal or state antitrust statute, including those prescribing price fixing between competitors and the allocation of customers among competitors;

(c) Committing a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid per capita or prepaid aggregate fixed-sum basis.

(12) Entities contracting on a prepaid per capita or prepaid aggregate fixed sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times between cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the Department of Health and Rehabilitative Services or the Department of Insurance, an amount equal to one and one-half times their monthly prepaid Medicaid revenues. If an entity's surplus falls below any applicable statutory requirements, or an entity's total of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the Department of Health and Rehabilitative Services or the Department of Insurance falls below one and one-half times its monthly prepaid Medicaid revenues, the Department of Health and Rehabilitative Services shall prohibit the entity from engaging in enrollment activities, shall cease to process new enrollments for the entity, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply to an entity if:

1. A public entity agrees to fund any deficit incurred by the contracting entity;

2. The entity's performance and obligations are guaranteed in writing by a nonprofit guaranteeing organization that:

a. Has been in operation for at least 5 years and has assets in excess of $50 million; and

b. Submits a written guarantee acceptable to the department which is irrevocable during the term of the contracting entity's contract with the department and, upon termination of the contract, until the department receives proof of satisfaction of all outstanding obligations incurred under the contract.

Section 14. Section 409.912, Florida Statutes, is created to read:

409.912 Oversight of the integrity of the Medicaid program.—The department shall operate a program to oversee the activities of Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible.

(1) The department shall conduct, or cause to be conducted by contract or otherwise, investigations, analyses, and audits of possible fraud, abuse, and neglect in the Florida Medicaid Program and shall report the findings therefrom in departmental audit reports as appropriate.

(2) The department may conduct, or may contract for, prepayment review of provider claims to ensure cost-effective purchasing, billing, and provision of care to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by the department, without any suspicion or allegation of fraud, abuse, or neglect.

(3) Any suspected criminal violation or fraudulent activity by a provider, or by the representative or agent of a provider, identified by the department must be referred to the Medicaid Fraud Control Unit of the Auditor General for investigation.

(4) A Medicaid provider is subject to having goods and services that are paid for by the Florida Medicaid Program reviewed by an appropriate peer review organization designated by the department.

(5) When presenting a claim for payment under the Florida Medicaid Program, a provider has an affirmative duty to supervise the provision of and be responsible for goods and services claimed to have been provided, to supervise and be responsible for preparing and submitting the claim, and to present a claim that is true and accurate and that is for goods and services which:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim;

(b) Are necessary;

(c) Are of a quality comparable to those furnished to the general public by the provider's peers;

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as may be authorized by the department; and

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(6) A Medicaid provider shall retain professional and financial records pertaining to services and goods furnished to a Medicaid recipient and billed to the Florida Medicaid Program for a period of 5 years after the date of furnishing such services or goods.

(7) The complaint and all information obtained pursuant to an investigation of a Medicaid provider, or the authorized representative or agent of a provider, relating to an allegation of fraud, abuse, or neglect is exempt from s. 119.07(1):

(a) Until the department takes final agency action respecting the provider and requires repayment of any overpayment or imposes an administrative sanction;

(b) Until the Auditor General refers the case for criminal prosecution;

(c) Until 10 days after the complaint is determined without merit; or

(d) At all times if the complaint or information is otherwise protected by law.

The exemption from s. 119.07(1) provided in this subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(8) The department may impose administrative sanctions against a Medicaid provider if:

(a) The provider has entered into a pretrial intervention or other first-offender agreement respecting a charge of, has pled nolo contendere or guilty to a charge of, has been found guilty regardless of adjudication of, or has been convicted of Medicaid fraud or any other Medicaid-related crime, such as theft, bribery, giving or receiving a kickback, or neglecting or physically abusing a recipient.

(b) The provider has pled guilty to, has been found guilty regardless of adjudication of, or has been convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession.

(c) The provider is excluded from the Medicare program for cause.

(d) The provider's license has not been renewed, or has been revoked, suspended, or terminated, by the licensing agency of any state.

(e) The provider is excluded from participating in the Medicaid or Medicare program by the Federal Government or any state.

(f) The provider has refused access to Medicaid-related records to an authorized auditor or investigator acting as an employee or agent of the department, the Auditor General, a state attorney, or the Federal Government.

(g) The provider has not furnished, upon reasonable notice, such Medicaid-related records as the department finds necessary to determine whether Medicaid payments are or were due and the amounts thereof.

(h) The provider is not in compliance with provisions of department policy manuals or handbooks which have been adopted by reference as rules in the Florida Administrative Code, state laws, federal rules and regulations, a provider agreement between the department and the provider, or certifications found on claim forms submitted by the provider or authorized representative as such provisions apply to the Florida Medicaid Program.

(i) The provider has furnished or ordered the furnishing to a recipient of goods or services that are inappropriate, unnecessary, excessive, or harmful to the recipient or are of inferior quality. Such determinations must be based on competent peer judgments and evaluations.

(j) The provider or an authorized representative of the provider has submitted or caused to be submitted false or erroneous Medicaid claims that have resulted in payments to the provider in excess of those to which the provider was entitled under the Florida Medicaid Program.

(k) The provider or an authorized representative of the provider has submitted or caused to be submitted a Medicaid provider enrollment application, request for prior authorization for Medicaid services, or Medicaid cost report that contains materially false or incorrect information.

(l) The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Florida Medicaid Program for the same service.

(m) The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX Reimbursement Plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable.

(n) The provider is indicted for fraudulent billing practices. The sanction applied for this reason is limited to suspending the provider from providing services under the Florida Medicaid Program for the duration of the indictment.

(o) The provider is found liable for negligent practice resulting in death or injury to his patient.

(p) The provider fails to demonstrate that it had available, during a specific audit or review period, sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Florida Medicaid Program.

(9) The department may impose any of the following sanctions on a provider for any of the acts described in subsection (8):

(a) Suspension for a specific period of time of not more than 1 year.

(b) Termination for a specific period of time of from more than 1 year to 20 years.

(c) Imposition of a fine of up to $1,000 for each violation not exceeding a total fine of $25,000 in connection with any one audit or investigation. Each day that an ongoing violation continues, such as refusing to furnish records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, or cost report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

(10) In determining the appropriate administrative sanction to be applied, the department shall consider:

(a) The seriousness and extent of the violation or violations;

(b) Any prior history of violations by the provider;

(c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation;

(d) Any pain and suffering inflicted by the provider on a recipient;

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates; and

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the department.

(11) The department may take action to sanction, suspend, or terminate a particular provider working for a group provider, and may suspend or terminate Medicaid participation at a specific location, rather than or in addition to taking action against an entire group, if it determines such action is in the best interest of Medicaid recipients.

(12) In making a determination of overpayment to a provider, the department shall use appropriate and valid auditing, accounting, analytical, statistical, or peer review methods or combinations thereof. Appropriate statistical methods include sampling and extension to the population, nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods include reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Florida Medicaid Program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period.

(13) When making a determination that an overpayment has occurred, the department shall prepare and issue a departmental audit report to the provider showing the calculation of overpayments.

(14) The departmental audit report showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not elicit testimony on direct examination or cross examination in any court hearing or administrative hearing regarding the purchase, barter, or inventory of drugs or supplies to challenge or impeach the result of the department's audit unless such purchase, barter, or inventory is documented by written purchase invoices, written inventory records, or other competent written evidence.

(15)(a) In an investigation of a violation by a provider pursuant to this section, the department may recover investigative and expert witness costs not exceeding $25,000 if a material violation is found and the department's findings were not contested by the provider or, if contested, the department ultimately prevailed.

(b) The department has the burden of documenting the investigative costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of investigative costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

(c) The provider may pay the investigative costs over a period to be determined by the department if the department determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of investigative costs may be collected by any means authorized by law for enforcement of a judgment.

(d) Investigative costs that are recovered must be returned to the department.

(16) If the department imposes an administrative sanction under this section for any of the acts described in subsection (8) upon any provider who is regulated by a state agency other than the department, the department shall notify that agency of the imposition of the sanction. Such notification must include the provider's name and license number and the specific reasons for sanction.

(17) The department may withhold Medicaid payments to a provider up to the amount of the alleged overpayment pending completion of an investigation under this section if it has reasonable cause to believe that the provider has committed one or more violations in relation to such payments. The department shall immediately withhold Medicaid payments to any provider found to present an immediate danger to the public health, safety, or welfare pursuant to a final order issued under s. 120.59(3). When payments are withheld under this subsection, however, the monthly Medicaid payment may not be reduced by more than 25 percent, and the payments withheld must be paid to the provider within 60 days with interest at the rate of 10 percent a year upon determining that a violation has not occurred.

Section 15. Section 409.913, Florida Statutes, is created to read:

409.913 Medicaid provider fraud.—

(1) For the purposes of this section, the term:

(a) "Fiscal agent" means any individual, firm, corporation, partnership, organization, or other legal entity that has contracted with the department to receive, process, and adjudicate claims under the Florida Medicaid Program.

(b) "Item or service" includes:

1. Any particular item, device, medical supply, or service claimed to have been provided to a recipient and listed in an itemized claim for payment; or

2. In the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim.

(c) "Knowingly" means done by a person who is aware or should be aware of the nature of his conduct and that his conduct is substantially certain to cause the intended result.

(2) Any person who:

(a) Knowingly makes, causes to be made, or aids and abets in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the department or its fiscal agent for payment is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Knowingly makes, causes to be made, or aids and abets in the making of a claim for items or services that are not authorized to be reimbursed by the Florida Medicaid Program is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Knowingly charges, solicits, accepts, or receives anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Florida Medicaid Program or knowingly fails to credit the department or its fiscal agent for any payment received from a third-party source is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(d) Knowingly makes or in any way causes to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that is or may be used by the department to determine a general or specific rate of payment for an item or service provided by a provider is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(e) Knowingly solicits, offers, pays, or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Florida Medicaid Program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Florida Medicaid Program is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(f) Knowingly fails to bill, or attempt to collect from a Medicaid recipient an authorized copayment for a Medicaid service that requires a copayment in return for specific Medicaid reimbursement is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(g) Knowingly submits false or misleading information or statements to the Florida Medicaid Program for the purpose of being accepted as a Medicaid provider is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) The repayment of Medicaid payments wrongfully obtained, or the offer or endeavor to repay Medicaid funds wrongfully obtained, does not constitute a defense to, or a ground for dismissal of, criminal charges brought under this section.

(4) All records in the custody of the department or its fiscal agent which relate to Medicaid provider fraud are business records within the meaning of s. 90.803(6).

(5) Proof that a claim was submitted to the department or its fiscal agent which contained a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to an inference that the person whose signature appears as the provider's authorizing signature on the claim form, or whose signature appears on a department electronic claim submission agreement submitted for claims made to the fiscal agent by electronic means, had knowledge of the false statement or false representation. This subsection applies whether the signature appears on the claim form or the electronic claim submission agreement by means of handwriting, typewriting, facsimile signature stamp, computer impulse, initials, or otherwise.

(6) Proof of submission to the department as its fiscal agent of a document containing items of income and expense used or that may be used by the department or its fiscal agent to determine a general or specific rate of payment and containing a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to the inference that the person who signed the certification of the document had knowledge of the false statement or representation. This subsection applies whether the signature appears on the document by means of handwriting, typewriting, facsimile signature stamp, electronic transmission, initials, or otherwise.

(7) Any person who agrees, conspires, combines, or confederates with another person to commit any act prohibited by subsection (2) is guilty of a misdemeanor of the first degree and is punishable as if he had actually committed such prohibited act. This subsection does not prohibit separate convictions and sentences for a violation of this subsection and a violation of any other provision of this section.

(8) A criminal action or proceeding under this section may be commenced at any time within 5 years after the cause of action accrues.

(9) The Auditor General shall conduct a statewide program of Medicaid fraud control. To accomplish this purpose, the Auditor General shall:

(a) Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Florida Medicaid Program, in the provision of medical assistance, or in the activities of providers of health care under the Florida Medicaid Program.

(b) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Florida Medicaid Program, in coordination with the department.

(c) Investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Florida Medicaid Program.

(d) Refer to the appropriate state attorney all violations indicating a substantial potential for criminal prosecution.

(e) Refer to the department all suspected abusive activities not of a criminal nature.

(f) Refer to the department for collection each instance of overpayment to a provider of health care under the Florida Medicaid Program which he discovers during the course of an investigation.

(g) Safeguard the privacy rights of all individuals and provide safeguards to prevent the use of patient medical records for any reason beyond the scope of a specific investigation for fraud or abuse, or both, without the patient's written consent.

(10) In carrying out his duties and responsibilities under this section, the Auditor General may:

(a) Enter upon the premises of any health care provider, excluding a physician, participating in the Florida Medicaid Program to examine all accounts and records that may, in any manner, be relevant in determining the existence of fraud in the Florida Medicaid Program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. A participating physician is required to make available any accounts or records that may, in any manner, be relevant in determining the existence of fraud in the Florida Medicaid Program. The accounts or records of a non-Medicaid patient may not be reviewed by, or turned over, to the Auditor General without the patient's written consent.

(b) Subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

Section 16. Section 409.914, Florida Statutes, is created to read:

409.914 County contributions to the Florida Medicaid Program.—Although the state is responsible for the full portion of the state share of the matching funds required for the Florida Medicaid Program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(1) Each county shall participate in the following items of care and service:

(a) Payments for inpatient hospitalization in excess of 12 days but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medically Needy Program.

(b) Payments for nursing home or intermediate facilities care in excess of $170 per month, with the exception of skilled nursing care for children under age 21.

(2) A county's participation must be 35 percent of the total cost of providing the items listed in subsection (1), except that the payments for items listed in paragraph (1)(b) may not exceed $55 per month per person.

(3) Each county shall set aside sufficient funds to pay for items of care and service provided to the county's eligible recipients for which county contributions are required, regardless of where in the state the care or service is rendered.

(4) Each county shall pay into the General Revenue Fund unallocated its pro rata share of the total county participation based upon statements rendered by the department in consultation with counties.

(5) The Department of Banking and Finance shall withhold from the cigarette tax receipts or any other funds to be distributed to the counties the individual county share that has not been remitted within 60 days after billing.

(6) In any county in which a special taxing district or authority is located which will benefit from the medical assistance programs covered by this section, the board of county commissioners may divide the county's financial responsibility for this purpose proportionately, and each such district or authority must furnish its share to the board of county commissioners in time for the board to comply with subsection (3). Any appeal of the proration made by the board of county commissioners must be made to the Department of Banking and Finance, which shall then set the proportionate share of each party.

Section 17. Section 409.915, Florida Statutes, is created to read:

409.915 Assistance to the other agencies.—The department shall use the claims payment systems, utilization control systems, cost control systems, case management systems, and other systems and controls that it has developed for the management and control of the Florida Medicaid Program to assist other agencies and entities, if appropriate, in paying claims and performing other activities necessary for the conduct of programs of state government, or for working with other public and private agencies to solve problems of lack of insurance, underinsurance, or uninsurability. When conducting these services, the department shall ensure:

(1) That full payment is received for services provided;

(2) That costs of providing these services are clearly segregated from costs necessary for the conduct of the Florida Medicaid Program; and

(3) That the program conducted serves the interests of the state in assuring that effective and quality health care at a reasonable cost is provided to the public.

Section 18. Section 409.916, Florida Statutes, is created to read:

409.916 Public Medical Assistance Trust Fund.—It is declared that access to adequate health care is a right that should be available to all Floridians. However, rapidly increasing health care costs threaten to make such care unaffordable for many citizens. The Legislature finds that unreimbursed health care services provided to persons who are unable to pay for such services cause the cost of services to paying patients to increase in a manner unrelated to the actual cost of services delivered. Further, the Legislature finds that the inequities between hospitals in the provision of unreimbursed services prevent hospitals that provide the bulk of such services from competing on an equitable economic basis with hospitals that provide relatively little care to indigent persons. Therefore, it is the intent of the Legislature to provide a method for funding the provision of health care services to indigent persons, the cost of which must be borne by the state and by hospitals that are granted the privilege of operating in this state.

(1) All moneys collected pursuant to s. 395.101 shall be deposited into the Public Medical Assistance Trust Fund, which is hereby created.

(2) There is hereby annually appropriated to the Public Medical Assistance Trust Fund $30 million from the General Revenue Fund.

(3) Moneys deposited in the Public Medical Assistance Trust Fund must be used solely for the purposes specified by law.

Section 19. Section 409.917, Florida Statutes, is created to read:

409.917 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the department shall distribute, pursuant to this section, moneys appropriated from the Public Medical Assistance Trust Fund to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.914, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) As used in this section, the term:

(a) "Adjusted patient days" means the sum of acute care patient days and intensive care patient days as reported to the Department of Health and Rehabilitative Services, divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Actual audited data" or "actual audited experience" means data reported to the Department of Health and Rehabilitative Services which has been audited in accordance with generally accepted auditing standards by the department or representatives under contract with the department.

(c) "Base Medicaid per diem" means the hospital's Medicaid per diem rate initially established by the Department of Health and Rehabilitative Services on July 1 of each state fiscal year. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution.

(d) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the Department of Health and Rehabilitative Services for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.

(e) "Charity care days" means the sum of the deductions from revenues for charity care minus 50 percent of restricted and unrestricted revenues provided to a hospital by local governments or tax districts, divided by gross revenues per adjusted patient day.

(f) "Disproportionate share percentage" means a rate of increase in the Medicaid per diem rate as calculated under this section.

(g) "Hospital" means a health care institution licensed as a hospital pursuant to chapter 395, but does not include an ambulatory surgical center.

(h) "Medicaid days" means the number of actual days attributable to Medicaid patients as determined by the Department of Health and Rehabilitative Services.

(2) The Department of Health and Rehabilitative Services shall use the following criteria to determine if a hospital qualifies for a disproportionate share payment:

(a) A hospital's total Medicaid days when combined with its total charity care days must equal or exceed 7 percent of its total adjusted patient days.

(b) A hospital's total charity care days weighted by a factor of 4.5 plus its total Medicaid days weighted by a factor of 1 must be equal to or greater than 10 percent of its total adjusted patient days.

(c) Additionally, in accordance with the Seventh Federal Omnibus Budget Reconciliation Act, a hospital with a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean or a hospital with a low-income utilization rate of 25 percent or greater shall qualify for reimbursement.

(3) In computing the disproportionate share rate:

(a) Per diem increases earned from disproportionate share shall be applied to each hospital's base Medicaid per diem rate and shall be capped at 100 percent.

(b) The department shall use the most recent calendar year audited data for the calculation of disproportionate share payments under this subsection.

(c) If the total amount earned by all hospitals under this subsection exceeds the amount appropriated, each hospital's share shall be reduced on a pro rata basis so that the total dollars distributed from the trust fund do not exceed the total amount appropriated.

(d) The total amount calculated to be distributed under this subsection shall be made in quarterly payments subsequent to each quarter during the fiscal year.

(4) Hospitals that qualify for a disproportionate share payment solely under paragraph (2)(c) shall have their payment calculated in accordance with the following formula:

$$TAA = TA \times (1/5.5)$$

$$DSHP = (HMD/TSMD) \times TAA$$

where:

TAA = total amount available.

TA = total appropriation.

DSHP = disproportionate share hospital payment.

HMD = hospital Medicaid days.

TSMD = total state Medicaid days.

(5) The following formula shall be used by the department to determine the maximum disproportionate share rate to be used to increase the Medicaid per diem rate for hospitals that qualify pursuant to paragraphs (2)(a) and (b).

$$DSR = \left(\left(\frac{CCD}{APD}\right) \times 4.5\right) + \left(\frac{MD}{APD}\right)$$

where:

APD = adjusted patient days.

CCD = charity care days.

DSR = disproportionate share rate.

MD = Medicaid days.

(6) The following criteria shall be used in determining the disproportionate share percentage:

(a) If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.

(b) If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, the disproportionate share percentage is 2.1544347.

(c) If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, the disproportionate share percentage is 4.6415888766.

(d) If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, the disproportionate share percentage is 10.0000001388.

(e) If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, the disproportionate share percentage is 21.544347299.

(f) If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, the disproportionate share percentage is 46.41588941.

(g) If the disproportionate share rate is greater than or equal to 60 percent, the disproportionate share percentage is 100.

(7) The following formula shall be used by the department to calculate the total amount earned by all hospitals under this subsection:

$$TAE = BMPD \times MD \times DSP$$

where:

TAE = total amount earned.

BMPD = base Medicaid per diem.

MD = Medicaid days.

DSP = disproportionate share percentage.

(8) In addition to the payments made under subsection (2)-(7), the department shall design and implement a system of making disproportionate share payments to those hospitals that participate in the Regional Perinatal Intensive Care Center program established pursuant to chapter 383. This system of payments must conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation

is made by making quarterly Medicaid payments. Notwithstanding s. 409.914, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(a) The following formula shall be used by the department to calculate the maximum additional disproportionate share rate for hospitals that participate in the Regional Perinatal Intensive Care Center program.

$$ADSR = \left(\frac{TAE}{STAE}\right)$$

where:

1. ADSR = additional disproportionate share rate.

2. STAE = sum of total amount earned by each hospital that participates in the Regional Perinatal Intensive Care Center program.

3. TAE = total amount earned by a Regional Perinatal Intensive Care Center under the disproportionate share program specified in subsection (2) for each hospital.

(b) The total additional payment for hospitals that participate in the Regional Perinatal Intensive Care Center program shall be calculated by the department as follows:

$$TAP = ADSR \times A$$

where:

1. A = amount appropriated for a Regional Perinatal Intensive Care Program hospital.

2. ADSR = additional disproportionate share rate for a Regional Perinatal Intensive Care Program hospital.

3. TAP = total additional payment.

(c) In order to receive payments under this subsection, a hospital must participate in the Regional Perinatal Intensive Care Center program, pursuant to chapter 383, and must meet the following additional requirements:

1. Agree to conform to all departmental requirements to assure high quality in the provision of service, including criteria adopted by departmental rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department deems appropriate as specified by rule.

2. Agree to provide information to the department, in a form and manner to be prescribed by rule of the department, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

3. Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

4. Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

5. Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

6. Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

7. Agree to provide backup and referral services to the department's county public health units and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

8. Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

(d) Hospitals that fail to comply with any of the conditions in paragraph (c) or the applicable rules of the department shall not receive any payments under this subsection until full compliance is achieved. A hospital that is not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed to the remaining participating Regional Perinatal Intensive Care Center program hospitals.

Section 20. Effective upon this act becoming a law, section 409.918, Florida Statutes, is created to read:

409.918 Extraordinary disproportionate share payments.—

(1) Subject to any limitations established within the General Appropriations Act or established pursuant to chapter 216, the department shall make a special extraordinary contribution to the care of indigent persons in this state. In order to be eligible to receive these funds, a hospital must:

(a) Be qualified to participate in the disproportionate share program specified in s. 409.917, popularly known as the "regular" disproportionate share program;

(b) Be qualified to participate in the disproportionate share program specified in s. 409.917(8), popularly known as the "RPICC" disproportionate share program; and

(c) Have a ratio of net charity care expenditures to net operating revenues that exceeds 10 percent.

(2) Payments made to an individual hospital from the total amount of funds to be disbursed under this program shall amount to the same percentage that each eligible hospital's regular disproportionate share payment comprises of the sum total of regular disproportionate share payments made to all hospitals eligible to participate in the extraordinary disproportionate share program.

(3) Each of the definitions and formulas specified in s. 409.917, shall be used, as applicable, for the purpose of computing the funds owed each hospital qualified under subsection (1), and paid in the appropriate percentage as specified in subsection (2).

(4) The department is authorized to receive funds from hospitals participating in the extraordinary disproportionate share program, and from local governments in whose jurisdiction a participating hospital resides, for the purpose of making payments, including federal matching funds, through the Medicaid extraordinary disproportionate share program. Funds received from hospitals or local governments for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.

(5) Payments made by the department to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.

(a) If the Federal Government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the department shall not distribute any additional funds and shall return all funds to the entity from which the funds were received, except as provided in paragraph (b).

(b) If the Federal Government imposes a restriction that still permits a partial or different distribution, the department may continue to disburse funds to hospitals participating in the extraordinary disproportionate share program in a federally approved manner, provided:

1. Each entity which contributes to the extraordinary disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each entity; and

2. The Executive Office of the Governor, the Office of Planning and Budget, the House of Representatives, and the Senate are provided at least 7 days' prior notice of the proposed change in the distribution, and do not disapprove such change.

(c) No distribution shall be made under the alternative method specified in paragraph (b) unless all parties agree or unless all funds of those parties that disagree which are not yet disbursed have been returned to those parties.

Section 21. Section 409.9185, Florida Statutes, is created to read:

409.9185 Disproportionate share program for teaching hospitals.—In addition to the payments made under the disproportionate share program and the extraordinary disproportionate share program, the Department of Health and Rehabilitative Services shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.914, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) On or before September 15 of each year, the Health Care Cost Containment Board shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the department shall distribute to each statutory teaching hospital, as defined in s. 407.002(27), an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined internal medicine and pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index which comprises three components:

1. The Health Care Cost Containment Board Service Index, computed by applying the standard Service Inventory Scores established by the Health Care Cost Containment Board to services offered by the given hospital, as reported on the Health Care Cost Containment Board Worksheet A-2 for the last fiscal year reported to the board before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Health Care Cost Containment Board Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Health Care Cost Containment Board to the volume of each service, expressed in terms of the standard units of measure reported on the Health Care Cost Containment Board Worksheet A-2 for the last fiscal year reported to the board before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) The following formula shall be used by the department to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

$$TAP = THAF \times A$$

where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

(3) The Health Care Cost Containment Board shall report to the department the statutory teaching hospital allocation fraction prior to October 1 of each year.

Section 22. Section 409.2666, Florida Statutes, 1990 Supplement, is transferred, renumbered as section 409.9186, Florida Statutes, and amended to read:

409.9186 ~~409.2666~~ Medicaid Research and Development Trust Fund.—

(1) There is hereby established in the accounts of the Department of Health and Rehabilitative Services the Medicaid Research and Development Trust Fund.

(2) The Legislature hereby finds and declares that because the Medicaid program is the second largest in state government and fastest growing, and because the Medicaid program serves a wide variety of persons with different needs and abilities, and because there is a continuing and growing need for health insurance, that there is a need for research and development concerning innovative programs of health care delivery and cost containment related to Medicaid. As a result, the Legislature intends that the department use the funds in the Medicaid Research and Development Trust Fund to:

(a) Stimulate the development of coordinated systems of health care for Medicaid recipients and the uninsured who may not be eligible for the Medicaid program;

(b) Better understand the costs and methods of care provided to Medicaid recipients, and seek ways to lower costs or improve care;

(c) Provide training in methods of care and successful reimbursement techniques to Medicaid providers;

(d) Recruit high-quality providers into the Medicaid program;

(e) Analyze and report on the adequacy of Medicaid rates in assuring access to quality providers; and

(f) Develop innovative, cost-effective, high-quality programs of care for Medicaid recipients.

(3) Any state funds deposited into the Medicaid Research and Development Trust Fund are subject to the General Appropriations Act. In no event shall the total state-funded appropriation level exceed 1 percent of the amount of rebates in any fiscal year or $1 million for any fiscal year, whichever is less. The use of such funds is limited as specified in the General Appropriations Act. Funds in the Medicaid Research and Development Trust Fund shall be matched with federal funds to the extent permitted by federal law.

~~(3) In fiscal year 1990-1991, the department shall address, to the extent funds are available, at least the following priorities in order of importance:~~

~~(a) The adequacy of existing reimbursement rates in accordance with s. 44, ch. 90-295, Laws of Florida;~~

~~(b) The feasibility of coordinating Medicaid coverage with a program of school-based health insurance for children and their families;~~

~~(c) The feasibility of using the Medicaid claims payment system in order to reduce the administrative costs of covering other uninsured Florida citizens; and~~

~~(d) The development of training programs in the care of high risk Medicaid recipients, particularly babies born to families with a history of illegal drug involvement.~~

(4) Funds not expended in the *Medicaid* ~~Medical~~ Research and Development Trust Fund shall carry over from year to year. *However, the department may request, at its discretion, that any funds in excess of the limit established in subsection (3) be transferred to another part of the Medicaid program pursuant to chapter 216.*

Section 23. Section 409.2667, Florida Statutes, 1990 Supplement, is transferred, renumbered as section 409.919, Florida Statutes, and amended to read:

409.919 ~~409.2667~~ Receipt and deposit of funds into the Medicaid Research and Development Trust Fund.—

(1) The Department of Health and Rehabilitative Services is authorized to receive funds from any person, given to the department for the purposes outlined in *s. 409.918* ~~s. 409.2666~~, and deposit them in the Medicaid Research and Development Trust Fund.

(2) The department shall deposit any funds received from pharmaceutical manufacturers, in the nature of rebates, and all other funds received by the department from any other person as the result of a cost-containment strategy, in the nature of a rebate, grant, or other similar mechanism, into the Medicaid Research and Development Trust Fund.

Section 24. Section 409.920, Florida Statutes, is created to read:

409.920 Rules.—The department shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements.

Section 25. Paragraph (d) of subsection (3) of section 110.123, Florida Statutes, 1990 Supplement, is amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(d)1. A person eligible to participate in the state group health insurance plan may be authorized by rules adopted by the Department of Administration, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The Department of Administration shall contract with health maintenance organizations to participate in the state group insurance program through a request for proposal based upon a premium and a minimum benefit package as follows:

a. The department shall establish a minimum benefit package to be provided by a participating HMO which shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO.

b. The department may establish a uniform schedule for deductibles and copayments for all participating HMOs.

c. Based upon the minimum benefit package and copayments and deductibles contained in sub-subparagraphs a. and b., the department shall issue a request for proposal for all HMOs which are interested in participating in the state group insurance program. Upon receipt of all proposals, the department may, as it deems appropriate, enter into contract negotiations with HMOs submitting bids. As part of the request for proposal process, the department may require detailed financial data from each HMO which participates in the bidding process for the purpose of determining the financial stability of the HMO.

d. In determining which HMOs to contract with, the department shall, at a minimum, consider: each proposed contractor's previous experience and expertise in providing prepaid health benefits; each proposed contractor's historical experience in enrolling and providing health care services to participants in the state group insurance program; the cost of the premiums; the plan's ability to adequately provide service coverage and administrative support services as determined by the department; plan benefits in addition to the minimum benefit package; accessibility to providers; and the financial solvency of the plan. Nothing shall preclude the department from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the department determines the plan has the best overall benefit package for the service areas involved. However, no HMO shall be eligible for a contract if the HMO's retiree Medicare premium exceeds the retiree rate as set by the department for the state group health insurance plan.

e. The department may limit the number of HMOs that it contracts with in each service area based on the nature of the bids it receives, the number of state employees in the service area, and any unique geographical characteristics of the service area. The department shall establish by rule service areas throughout the state.

f. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

3. The department is authorized to negotiate and contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The department may establish, subject to legislative approval pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums. A report shall be submitted to the Legislature by February 1, 1990, regarding establishment of any regional plan and its effect on the State Group Health Trust Fund.

4. In addition to contracting pursuant to subparagraph 2., the department shall enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under *the Florida Medicaid Program* ~~s. 409.266~~;

b. Does not currently meet the 25 percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health and Human Services excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a. through d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal process described in subparagraph 2.

5. All enrollees in the state group health insurance plan or any health maintenance organization plan shall have the option of changing to any other health plan which is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year.

6. Any HMO participating in the state group insurance program shall, upon the request of the department, submit to the department standardized data for the purpose of comparison of the appropriateness, quality, and efficiency of care provided by the HMO. Such standardized data shall include: membership profiles; inpatient and outpatient utilization by age and sex, type of service, provider type, and facility; and emergency care experience. Requirements and timetables for submission of such standardized data and such other data as the department deems necessary to evaluate the performance of participating HMOs shall be promulgated by rule.

Section 26. Subsection (1) of section 154.011, Florida Statutes, is amended to read:

154.011 Primary care services.—

(1) It is the intent of the Legislature that all 67 counties offer primary care services through contracts, as required by s. 154.01(3), for Medicaid recipients and other qualified low-income persons. Therefore, beginning July 1, 1987, the Department of Health and Rehabilitative Services is directed, to the extent that funds are appropriated, to develop a plan to implement a program in cooperation with each county. The department shall coordinate with the county's primary care panel, as created by s. 154.013, or with the county's governing body if no primary care panel is appointed. Such primary care programs shall be phased-in and made operational as additional resources are appropriated ~~pursuant to s. 409.266(7)(e),~~ and shall be subject to the following:

(a) The department shall enter into contracts with the county governing body for the purpose of expanding primary care coverage. The county governing body shall have the option of organizing the primary care programs through county public health units or through county public hospitals owned and operated directly by the county. The department shall, as its first priority, maximize the number of counties participating in the primary care programs under this section, but shall establish priorities for funding based on need and the willingness of counties to participate. The department shall select counties for programs through a formal request-for-proposal process that requires compliance with program standards for cost-effective quality care and seeks to maximize access throughout the county.

(b) Each county's primary care program may utilize any or all of the following options of providing services: offering services directly through the county public health units; contracting with individual or group practitioners for all or part of the service; or developing service delivery models which are organized through the county public health units but which utilize other service or delivery systems available, such as federal primary care programs or prepaid health plans. In addition, counties shall have the option of pooling resources and joining with neighboring counties in order to fulfill the intent of this section.

(c) Each primary care program shall conform to the requirements and specifications of the department, and shall at a minimum:

1. Adopt a minimum eligibility standard of at least 100 percent of the federal nonfarm poverty level.

2. Provide a comprehensive mix of preventive and illness care services.

3. Be family oriented and be easily accessible regardless of income, physical status, or geographical location.

4. Ensure 24-hour telephone access and offer evening and weekend clinic services.

5. Offer continuity of care over time.

6. Make maximum use of existing providers and closely coordinate its services and funding with existing federal primary care programs, especially in rural counties, to ensure efficient use of resources.

7. Have a sliding fee schedule based on income for eligible persons above 100 percent of the federal nonfarm poverty level.

8. Include quality assurance provisions and procedures for evaluation.

9. Provide early periodic screening diagnostic and treatment services for Medicaid-eligible children.

10. Fully utilize and coordinate with rural hospitals for outpatient services, including contracting for services when advisable in terms of cost-effectiveness and feasibility.

Section 27. Subsection (7) of section 394.4787, Florida Statutes, 1990 Supplement, is amended to read:

394.4787 Definitions.—As used in this act:

(7) "PMATF" means the Public Medical Assistance Trust Fund ~~as created in s. 409.2662~~.

Section 28. Subsection (2) of section 395.01465, Florida Statutes, 1990 Supplement, is amended to read:

395.01465 Emergency care hospitals.—

(2) For the purpose of Medicaid swing-bed reimbursement pursuant to *the Florida Medicaid Program* ~~s. 409.266(19)~~, the department shall treat emergency care hospitals in the same manner as hospitals defined in s. 395.102(2).

Section 29. Paragraph (b) of subsection (1) of section 400.126, Florida Statutes, is amended to read:

400.126 Receivership proceedings.—

(1) As an alternative to or in conjunction with an injunctive proceeding, the department may petition a court of competent jurisdiction for the appointment of a receiver, when any of the following conditions exist:

(b) The licensee is closing the facility or has informed the department that it intends to close the facility and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the facility. However, the failure on the part of the department, after receiving notice of the closing of a facility that is certified to provide services under Title XIX of the Social Security Act, a minimum of 90 days prior to the closing date, to make adequate arrangement for relocating those residents who are receiving assistance under *the Florida Medicaid Program* ~~s. 409.266~~ shall in and of itself not be grounds to petition for the appointment of a receiver. Under these circumstances, if a facility remains open beyond the closing date, the department shall reimburse the facility for all costs incurred, up to the cap, for those residents who are receiving assistance under *the Florida Medicaid Program* ~~s. 409.266~~, provided the facility continues to be licensed pursuant to this part and certified to provide services under Title XIX of the Social Security Act.

Section 30. Subsection (1) of section 400.18, Florida Statutes, is amended to read:

400.18 Closing of nursing facility.—

(1) Whenever a licensee voluntarily discontinues operation, and during the period when it is preparing for such discontinuance, it shall inform the department not less than 90 days prior to the discontinuance of operation. The licensee also shall inform the resident or the next of kin, legal representative, or agency acting on behalf of the resident of the fact, and the proposed time, of such discontinuance and give at least 90 days' notice so that suitable arrangements may be made for the transfer and care of the resident. In the event any resident has no such person to represent him, the licensee shall be responsible for securing a suitable transfer of the resident before the discontinuance of operation. The department shall be responsible for arranging for the transfer of those residents requiring transfer who are receiving assistance under *the Florida Medicaid Program* ~~s. 409.266~~.

Section 31. Section 400.332, Florida Statutes, is amended to read:

400.332 Funds received not revenues for purpose of *the Florida Medicaid* ~~medical assistance~~ Program.—Any funds received by a nursing home in connection with its participation in the geriatric outpatient nurse clinic program shall not be considered as revenues for purposes of cost reports under the *Florida Medicaid* ~~medical assistance~~ Program ~~as set forth in s. 409.266~~.

Section 32. Subsection (2) of section 407.51, Florida Statutes, is amended to read:

407.51 Exceeding approved budget or previous year's actual experience by more than maximum rate of increase; allowing or authorizing operating revenue or expenditures to exceed amount in approved budget; penalties.—

(2) Penalties shall be assessed as follows:

(a) For the first occurrence within a 5-year period, the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 5 percent; and, if such excess is greater than 5 percent over the maximum allowable rate of increase, any amount in excess of 5 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund~~, as created in s. 409.2662~~.

(b) For the second occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 2 percent; and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:

1. Levy a fine against the hospital in the total amount of the excess to be deposited in the Public Medical Assistance Trust Fund.

2. Notify the Department of Health and Rehabilitative Services of the violation, whereupon the department shall not accept any application for a certificate of need pursuant to ss. 381.701-381.7155 from or on behalf of such hospital until such time as the hospital has demonstrated to the satisfaction of the board that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected or amended budget or its applicable maximum allowable rate of increase for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.

3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the Department of Health and Rehabilitative Services, whereupon the department shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital *from the Public Medical Assistance Trust Fund* ~~pursuant to s. 409.266(7) or s. 409.2663~~. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital through the *Public Medical Assistance Trust Fund* ~~operation of s. 409.266(7) or s. 409.2663~~. It is the responsibility of the hospital to demonstrate to the satisfaction of the board its entitlement to such reduction. It is the intent of the Legislature that the Health Care Cost Containment Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix. For psychiatric hospitals, the board shall also reduce the amount of excess by utilizing as a proxy for case mix the change in a hospital's audited actual average length of stay as compared to the previous year's audited actual average length of stay without any thresholds or limitations.

Section 33. Paragraph (c) of subsection (6) of section 409.2673, Florida Statutes, 1990 Supplement, is amended to read:

409.2673 Shared county and state health care program for low-income persons; trust fund.—

(6)

(c) The state's portion of the funding shall be made available from the Public Medical Assistance Trust Fund~~, created under s. 409.2662,~~ or from other funds appropriated by the Legislature.

Section 34. Subsection (10) of section 409.345, Florida Statutes, is amended to read:

409.345 Public assistance payments to constitute debt of recipient.—

(10) PUBLIC ASSISTANCE.—For the purposes of this section, the term "public assistance" *includes* ~~shall include~~ all money payments made to or on behalf of a recipient, including, but not limited to, assistance received under ss. 409.235 *and*~~,~~ 409.255, *the Florida Medicaid Program,* ~~and 409.266~~ and mandatory and optional supplement payments under the Social Security Act.

Section 35. Paragraph (d) of subsection (5) of section 409.701, Florida Statutes, 1990 Supplement, is amended to read:

409.701 The Florida Health Access Corporation Act.—

(5) LICENSING, FISCAL OPERATION.—

(d) The corporation may expend funds through direct reinsurance, by purchasing reinsurance, or by other means approved by the board for the program of health care services and benefits arranged through the corporation. The amount of such expenditure *may* ~~shall~~ not exceed funds allocated from the Public Medical Assistance Trust Fund ~~as provided in s. 409.2662(4)~~ or other sources of funding arranged by the corporation. Notwithstanding the provisions of s. 216.301, any amount so provided, which is not annually required for such purposes, shall remain available to the corporation, to be supplemented by an annual amount equal to the amount expended in the prior year, for the purpose of meeting funding requirements in succeeding years. Any amount remaining upon the liquidation or dissolution of the corporation shall be returned to the Public Medical Assistance Trust Fund.

Section 36. Section 410.036, Florida Statutes, is amended to read:

410.036 Eligibility for services.—Criteria for determining eligibility for this program shall be the same as criteria used to determine eligibility for assistance under Title XVI of the Social Security Act, as the same exists on July 1, 1977, or shall be the same as financial criteria used to determine eligibility for nursing home care under *the Florida Medicaid Program* ~~s. 409.266~~.

Section 37. Paragraph (a) of subsection (9) of section 624.424, Florida Statutes, 1990 Supplement, is amended to read:

624.424 Annual statement and other information.—

(9)(a) Each authorized insurer shall, pursuant to *s. 409.910(20)* ~~s. 409.2665(22)~~, provide records and information to the Department of Health and Rehabilitative Services to identify potential insurance coverage for claims filed with that department and its fiscal agents for payment of medical services under *the Florida Medicaid Program* ~~s. 409.266~~.

Section 38. Subsection (4) of section 627.736, Florida Statutes, 1990 Supplement, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority.—

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Department of Health and Rehabilitative Services provides, pays, or becomes liable for medical assistance under Medicaid pursuant to chapter 409, related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of *s. 409.910* ~~s. 409.2665~~.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. However, any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

(c) All overdue payments shall bear simple interest at the rate of 10 percent per year.

(d) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., provided the relative at the time of the accident is domiciled in the owner's household and is not himself the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle, provided the injured person is not himself:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner or owners of such a motor vehicle.

(e) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(f) Medical payments insurance, if available in a policy of motor vehicle insurance, shall pay the portion of any claim for personal injury protection medical benefits which is otherwise covered but is not payable due to the coinsurance provision of paragraph (1)(a), regardless of whether the full amount of personal injury protection coverage has been exhausted. The benefits shall not be payable for the amount of any deductible which has been selected.

Section 39. Section 631.813, Florida Statutes, is amended to read:

631.813 Application of part.—This part shall apply to HMO contractual obligations to residents of Florida by HMOs possessing a valid certificate of authority issued by the Florida Department of Insurance as provided by part II of chapter 641. The provisions of this part shall not apply to persons participating in medical assistance programs *under the Florida Medicaid Program* ~~created pursuant to s. 409.266~~.

Section 40. Subsection (1) of section 641.261, Florida Statutes, 1990 Supplement, is amended to read:

641.261 Other reporting requirements.—

(1) Each authorized health maintenance organization shall provide records and information to the Department of Health and Rehabilitative Services pursuant to *s. 409.910(20)* ~~s. 409.2665(22)~~ for the sole purpose of identifying potential coverage for claims filed with the Department of Health and Rehabilitative Services and its fiscal agents for payment of medical services under *the Florida Medicaid Program* ~~s. 409.266~~.

Section 41. Subsection (14) of section 641.31, Florida Statutes, 1990 Supplement, is amended to read:

641.31 Health maintenance contracts.—

(14) Whenever a subscriber of a health maintenance organization is also a Medicaid recipient, the health maintenance organization's coverage shall be primary to the recipient's Medicaid benefits and the organization shall be a third party subject to the provisions of *s. 409.910* ~~s. 409.2665~~.

Section 42. Subsection (1) of section 641.411, Florida Statutes, 1990 Supplement, is amended to read:

641.411 Other reporting requirements.—

(1) Each prepaid health clinic shall provide records and information to the Department of Health and Rehabilitative Services pursuant to *s. 409.910(20)* ~~s. 409.2665(22)~~ for the sole purpose of identifying potential coverage for claims filed with the Department of Health and Rehabilitative Services and its fiscal agents for payment of medical services under *the Florida Medicaid Program* ~~s. 409.266~~.

Section 43. Paragraph (b) of subsection (2) of section 768.73, Florida Statutes, is amended to read:

768.73 Punitive damages; limitation.—

(2) In any civil action, an award of punitive damages shall be payable as follows:

(b) If the cause of action was based on personal injury or wrongful death, 60 percent of the award shall be payable to the Public Medical Assistance Trust Fund ~~created in s. 409.2662~~; otherwise, 60 percent of the award shall be payable to the General Revenue Fund.

Section 44. Paragraph (a) of subsection (1) of section 895.02, Florida Statutes, 1990 Supplement, is amended to read:

895.02 Definitions.—As used in ss. 895.01-895.08, the term:

(1) "Racketeering activity" means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce, or intimidate another person to commit:

(a) Any crime which is chargeable by indictment or information under the following provisions of the Florida Statutes:

1. Section 210.18, relating to evasion of payment of cigarette taxes.

2. Section 403.727(3)(b), relating to environmental control.

3. Section 409.325, relating to public assistance fraud.

4. Section 409.913, relating to Medicaid provider fraud.

5. ~~4.~~ Chapter 517, relating to sale of securities and investor protection.

6. ~~5.~~ Section 550.24, s. 550.35, or s. 550.36, relating to dogracing, horseracing, and jai alai frontons.

7. ~~6.~~ Section 551.09, relating to jai alai frontons.

8. ~~7.~~ Chapter 552, relating to the manufacture, distribution, and use of explosives.

9. ~~8.~~ Chapter 562, relating to beverage law enforcement.

10. ~~9.~~ Section 655.50, relating to reports of currency transactions, when such violation is punishable as a felony.

11. ~~10.~~ Chapter 687, relating to interest and usurious practices.

12. ~~11.~~ Section 721.08, s. 721.09, or s. 721.13, relating to real estate time-share plans.

13. ~~12.~~ Chapter 782, relating to homicide.

14. ~~13.~~ Chapter 784, relating to assault and battery.

15. ~~14.~~ Chapter 787, relating to kidnapping.

16. ~~15.~~ Chapter 790, relating to weapons and firearms.

17. ~~16.~~ Section 796.01, s. 796.03, s. 796.04, s. 796.05, or s. 796.07, relating to prostitution.

18. ~~17.~~ Chapter 806, relating to arson.

19. ~~18.~~ Chapter 812, relating to theft, robbery, and related crimes.

20. ~~19.~~ Chapter 815, relating to computer-related crimes.

21. ~~20.~~ Chapter 817, relating to fraudulent practices, false pretenses, fraud generally, and credit card crimes.

22. ~~21.~~ Section 827.071, relating to commercial sexual exploitation of children.

23. ~~22.~~ Chapter 831, relating to forgery and counterfeiting.

24. ~~23.~~ Chapter 832, relating to issuance of worthless checks and drafts.

25. ~~24.~~ Section 836.05, relating to extortion.

26.~~25.~~ Chapter 837, relating to perjury.

27.~~26.~~ Chapter 838, relating to bribery and misuse of public office.

28.~~27.~~ Chapter 843, relating to obstruction of justice.

29.~~28.~~ Section 847.011, s. 847.012, s. 847.013, s. 847.06, or s. 847.07, relating to obscene literature and profanity.

30.~~29.~~ Section 849.09, s. 849.14, s. 849.15, s. 849.23, or s. 849.25, relating to gambling.

31.~~30.~~ Chapter 893, relating to drug abuse prevention and control.

32.~~31.~~ Chapter 896, relating to offenses related to financial transactions.

33.~~32.~~ Sections 914.22 and 914.23, relating to tampering with a witness, victim, or informant, and retaliation against a witness, victim, or informant.

34.~~33.~~ Sections 918.12 and 918.13, relating to tampering with jurors and evidence.

Section 45. For the purpose of incorporating the amendment to section 895.02, Florida Statutes, 1990 Supplement, in references thereto, paragraph (g) of subsection (3) of section 655.50, Florida Statutes, is reenacted to read:

655.50 Florida Control of Money Laundering in Financial Institutions Act; reports of transactions involving currency; when required; purpose; definitions; penalties.—

(3) As used in this section, the term:

(g) "Specified unlawful activity" means any "racketeering activity" as defined in s. 895.02.

Section 46. For the purpose of incorporating the amendment to section 895.02, Florida Statutes, 1990 Supplement, in references thereto, paragraph (g) of subsection (1) of section 896.101, Florida Statutes, 1990 Supplement, is reenacted to read:

896.101 Offense of conduct of financial transaction involving proceeds of unlawful activity; penalties.—

(1) Definitions.—As used in this section, the term:

(g) "Specified unlawful activity" means any "racketeering activity" as defined in s. 895.02.

Section 47. Rules adopted by the Department of Health and Rehabilitative Services prior to October 1, 1991, under the authority of any statutory provision amended or repealed by this act shall remain in effect and shall be administered by the department until the department adopts rules that supersede those rules.

Section 48. There is hereby created within the Executive Office of the Governor the Task Force on County Contributions to Medicaid. The task force shall be composed of the following 11 members:

(1)(a) The Secretary of Health and Rehabilitative Services or his designee.

(b) Four members to be appointed by the Governor.

(c) Five members to be appointed by the Florida Association of Counties, who shall each represent a different county.

(d) The Comptroller or his designee.

(2) The task force shall study the current method for county Medicaid billing, as required by section 409.914, Florida Statutes, shall prepare recommendations regarding the adequacy of these current procedures, and shall propose any revisions necessary to facilitate prompt payment and to assist counties in budgeting for this expense. A report containing the findings and recommendations of the task force shall be submitted to the Legislature and the Governor on or before February 1, 1992.

(3) The sum of $15,000 is appropriated from the Public Medical Assistance Trust Fund to the task force for the purpose of carrying out the provisions of this section.

Section 49. Any diagnosis-specific supplemental funding to a nursing home does not prevent, or create a disincentive for, a terminally ill individual who resides in the nursing home who is eligible to receive Medicare or Medicaid benefits from electing to receive such benefits for hospice care or services.

Section 50. Section 21 of chapter 89-275, Laws of Florida; subsection (3) of section 400.23, Florida Statutes, as amended by section 1 of chapter 90-125, Laws of Florida; section 409.266, Florida Statutes, as amended by section 5 of chapter 90-232, Laws of Florida, section 10 of chapter 90-284, Laws of Florida, sections 17 and 34 of chapter 90-295, Laws of Florida, and section 6 of chapter 90-341, Laws of Florida; and sections 409.2662, 409.2663, 409.2664, 409.267, 409.2671, and 409.268, Florida Statutes, are repealed.

Section 51. There is appropriated to the Health Care Cost Containment Board, for fiscal year 1991-1992, six positions and $167,079 to fund the implementation of the assessments on health care facilities created in this act. These funds shall be transferred from the Public Medical Assistance Trust Fund to the Health Care Cost Containment Board Trust Fund.

Section 52. Section 641.201, Florida Statutes, is amended to read:

641.201 Applicability of other laws.—Except as provided in this part, health maintenance organizations *are* ~~shall be~~ governed by the provisions of this part and *are* ~~part IV of this chapter and shall be~~ exempt from all other provisions of the Florida Insurance Code.

Section 53. Section 641.21, Florida Statutes, is amended to read:

641.21 Application for certificate.—

(1) Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. ~~The department shall accept and shall begin its review of an application for a certificate of authority anytime after an organization has filed an application for a Health Care Provider Certificate pursuant to part IV of this chapter. However, the department shall not issue a certificate of authority to any applicant which does not possess a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services.~~ Each application for a certificate shall be on such form as the department shall prescribe and shall be accompanied by the following:

(a) A copy of the articles of incorporation and all amendments thereto.;

(b) A copy of the bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant.;

(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the health maintenance organization, including all officers, directors, and owners of in excess of 5 percent of the common stock of the corporation. Such persons shall fully disclose to the department and the directors of the health maintenance organization the extent and nature of any contracts or arrangements between them and the health maintenance organization, including any possible conflicts of interest.;

(d) A statement generally describing the health maintenance organization, its operations, and its grievance procedures.;

(e) Forms of all health maintenance contracts, certificates, and member handbooks the applicant proposes to offer the subscribers, showing the benefits to which they are entitled, together with a table of the rates charged, or proposed to be charged, for each form of such contract. A certified actuary shall:

1. Certify that the rates are *not* ~~neither~~ inadequate, ~~nor~~ excessive, *or* ~~nor~~ unfairly discriminatory;

2. Certify that the rates are appropriate for the classes of risks for which they have been computed; and

3. File an adequate description of the rating methodology showing that such methodology follows consistent and equitable actuarial principles.;

(f) A statement describing with reasonable certainty the geographic area or areas to be served by the health maintenance organization.;

(g) An audited financial statement prepared on the basis of statutory accounting principles and certified by an independent certified public

accountant, except that surplus notes acceptable to the department and meeting the requirements of this act shall be included in the calculation of surplus.~~; and~~

(h) A statement describing the manner in which health services shall be regularly available.

(i) The locations of the facilities at which health care services shall be regularly available to subscribers.

(j) The type of health care personnel engaged to provide the health care services and the quantity of the personnel of each type.

(k) A statement giving the projected number of subscribers to be enrolled yearly for the next 3 years.

(l) A statement indicating the source of emergency care on a 24-hour basis.

(m) A statement that the physicians employed by the applicant have been formally organized as a medical staff and that the applicant's governing body has designated a chief of medical staff.

(n) A statement describing the manner in which the organization assures the maintenance of a medical records system in accordance with accepted medical records' standards and practices.

(o) If general anesthesia is to be administered in a facility that is not licensed by the Department of Health and Rehabilitative Services, a copy of architectural plans to meet the requirements for institutional occupancy (NFPA 101 Life Safety Code, current edition as adopted by the State Fire Marshal).

(p) A description of the organization's quality assurance program, including committee structure, criteria and procedures for corrective action which complies with s. 641.3010.

(q) A description and supporting documentation concerning how the applicant will comply with the internal risk management program requirements.

(r) An explanation of how coverage is to be effected outside the health maintenance organization's stated geographic area for emergency services.

(s) A comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant. The study shall be for the greater of 3 years or until the health maintenance organization has been projected to be profitable for 12 consecutive months. The study must show that the health maintenance organization would not, at the end of any month of the projection period, have less than the minimum surplus as required by s. 641.225.

(t)~~(h)~~ Such additional reasonable data, financial statements, and other pertinent information as the department may require with respect to the determination that the applicant can provide the services to be offered.

(2) After submission of the application for a certificate of authority, the entity may engage in initial group marketing activities solely with respect to employers, representatives of labor unions, professional associations, and trade associations, so long as it does not enter into, issue, deliver, or otherwise effectuate health maintenance contracts, effectuate or bind coverage or benefits, provide health care services, or collect premiums or charges until it has been issued a certificate of authority by the department. Any such activities, oral or written, shall include a statement that the entity does not possess a valid certificate of authority and cannot enter into health maintenance contracts until such time as it has been issued a certificate of authority by the department.

(3) Any person or entity which enters into a contract with the Department of Health and Rehabilitative Services on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of health care services or social services, or both, to persons determined eligible for such services *is* ~~shall be~~ exempt from ~~the provisions of~~ this *part* ~~chapter~~ and shall be governed by the standards set forth by the Department of Health and Rehabilitative Services unless the person or entity provides health care services on a prepaid basis to persons other than those for which the Department of Health and Rehabilitative Services has contracted. However, any person or entity which is not certificated under ~~the provisions of~~ this *part may* ~~chapter shall~~ not use in its name, logo, contracts, or literature the *phrase* ~~phrases "health care service plan,"~~ "health maintenance organization," ~~or "prepaid health clinic"~~ or the initials "HMO" ~~or "PHC"~~; imply, directly or indirectly, that it is a ~~health care services plan,~~ health maintenance organization~~, or prepaid health clinic~~; or hold itself out to be a ~~health care services plan,~~ health maintenance organization~~, or prepaid health clinic~~. A prepaid plan exempt under this subsection *is* ~~shall be~~ subject to regulation by the Department of Health and Rehabilitative Services ~~in accordance with s. 641.48(3)~~. *The Department of Health and Rehabilitative Services shall set standards and adopt rules in accordance with the Medicaid program and provisions in chapter 409 for conducting a prepaid plan which is exempt under this subsection.*

~~(4) A comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant. The study shall be for the greater of 3 years or until the health maintenance organization has been projected to be profitable for 12 consecutive months. The study must show that the health maintenance organization would not, at the end of any month of the projection period, have less than the minimum surplus as required by s. 641.225.~~

Section 54. Section 641.22, Florida Statutes, is amended to read:

641.22 Issuance of certificate of authority.—The department shall issue a certificate of authority to any entity filing a completed application in conformity with s. 641.21, upon payment of the prescribed fees and upon the department's being satisfied that:

~~(1) As a condition precedent to the issuance of any certificate, the entity has obtained a Health Care Provider Certificate from the Department of Health and Rehabilitative Services pursuant to part IV of this chapter.~~

(1)~~(2)~~ The health maintenance organization is actuarially sound.

(2)~~(3)~~ The entity has met the applicable requirements specified in s. 641.225.

(3)~~(4)~~ The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status. However, this section does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit experience rating.

(4)~~(5)~~ The entity furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care.

(5)~~(6)~~ The ownership, control, and management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The department *may* ~~shall~~ not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which the department has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors.

(6)~~(7)~~ The entity has a blanket fidelity bond in the amount of $100,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with the funds. All employees handling the funds shall be covered by the blanket fidelity bond. An agent licensed under the provisions of the Florida Insurance Code may either directly or indirectly represent the health maintenance organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any health maintenance organization subscriber's contract or collect or forward any consideration paid by the subscriber to the health maintenance organization; and the licensed agent *is* ~~shall~~ not ~~be~~ required to post the bond required by this subsection.

(7)~~(8)~~ The entity has filed with the department, and obtained approval from the department of, all reinsurance contracts as provided in s. 641.285.

(8)~~(9)~~ The health maintenance organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

(9) The entity has the ability to provide care of a quality consistent with prevailing professional standards applicable to delivery of health care services. In making this determination, the department shall require the entity to:

(a) Demonstrate its capability to provide health care services in the geographical area it services.

(b) Ensure that the health care services it provides to subscribers, including the physician services described by s. 641.19(7)(d) and (e), are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs.

(c) Exercise reasonable care in assuring that services provided are performed by providers who are licensed to provide such services.

(d) Have a system for verifying and examining the credentials of each of its providers. The organization shall maintain in a central file the credentials, including a copy of the current Florida license, of each of its physicians.

(e) Establish standards and procedures reasonably necessary to maintain a readily accessible medical records system which is adequate to provide necessary information including an accurate documentation of all services provided for every enrolled person.

(f) Inform subscribers in contracts, certificates, and subscriber handbooks, when applicable, that certain types of described medical procedures may be provided by individuals who are not licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

Section 55. Section 641.221, Florida Statutes, is amended to read:

641.221 Continued eligibility for certificate of authority*; expansion of services to a new area.*—

(1) In order to maintain its eligibility for a certificate of authority, a health maintenance organization *must* ~~shall~~ continue to meet all conditions required to be met under this part and the rules *adopted under this part* ~~promulgated thereunder~~ for the initial application for and issuance of its certificate of authority under s. 641.22.

(2) Each health maintenance organization shall notify the department of its intent to expand its geographic area at least 60 days prior to the date it begins providing health care services in the new area. Prior to the date the health maintenance organization begins enrolling members in the new area, it must submit a notarized affidavit, signed by two officers of the organization who have the authority to bind the organization, to the department describing and affirming its existing and projected capability to provide health care services to its projected number of subscribers in the new area. The notarized affidavit shall further assure that, 15 days prior to providing services in the new area, the health maintenance organization shall be able, through documentation or otherwise, to demonstrate that it shall be capable of providing services to its projected subscribers for at least the first 60 days of operation. If the department determines that the organization is not capable of providing health care services to its projected number of subscribers in the new area, the department may issue an order pursuant to the procedures of chapter 120 prohibiting the organization from expanding into the new area. In any proceeding pursuant to chapter 120, the department has the burden of establishing that the organization is not capable of providing health care services to its projected number of subscribers in the new area.

Section 56. Section 641.23, Florida Statutes, is amended to read:

641.23 Revocation ~~or cancellation~~ of certificate of authority; suspension of enrollment of new subscribers; terms of suspension*; penalty for use of unlicensed providers.*—

~~(1) The maintenance of a valid and current Health Care Provider Certificate issued pursuant to part IV of this chapter is a condition of the maintenance of a valid and current certificate of authority issued by the department to operate a health maintenance organization. Denial, revocation, or nonrenewal of a Health Care Provider Certificate shall be deemed to be an automatic and immediate cancellation of a health maintenance organization's certificate of authority.~~

(1)~~(2)~~ The department may suspend the authority of a health maintenance organization to enroll new subscribers or revoke any certificate issued to a health maintenance organization, or order compliance within 30 days, if it finds that any of the following conditions exists:

(a) The organization is not operating in compliance with this part;

(b) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by this part;

(c) The existing contract rates are excessive, inadequate, or unfairly discriminatory;

(d) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising; ~~or~~

(e) The organization is insolvent*; or*.

(f) The organization has refused to be examined pursuant to s. 641.275, produce its accounts, records, and files for examination, or perform any other legal obligation as to such examination, when required by the department.

(2)~~(3)~~ Whenever the financial condition of the health maintenance organization is such that, if not modified or corrected, its continued operation would result in impairment or insolvency, the department may order the health maintenance organization to file with the department and implement a corrective action plan designed to do one or more of the following:

(a) Reduce the total amount of present potential liability for benefits by reinsurance or other means.

(b) Reduce the volume of new business being accepted.

(c) Reduce the expenses of the health maintenance organization by specified methods.

(d) Suspend or limit the writing of new business for a period of time.

(e) Require an increase in the health maintenance organization's net worth.

If the health maintenance organization fails to submit a plan within 30 days *after* ~~of~~ the department's order or submits a plan which is insufficient to correct the health maintenance organization's financial condition, the department may order the health maintenance organization to implement one or more of the corrective actions listed in this subsection.

(3)~~(4)~~ The department shall, in its order suspending the authority of a health maintenance organization to enroll new subscribers, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the health maintenance organization prior to reinstatement of its authority to enroll new subscribers. The order of suspension is subject to rescission or modification by further order of the department prior to the expiration of the suspension period. Reinstatement *may* ~~shall~~ not be made unless requested by the health maintenance organization; however, the department *may* ~~shall~~ not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(4) Revocation of a health maintenance organization's certificate of authority shall be for a period of 2 years. After 2 years, the organization may apply for a new certificate by complying with all application requirements applicable to first-time applicants.

(5) Any health maintenance organization which knowingly uses the services of a provider who is not licensed or otherwise authorized by law to provide such services is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 57. Section 641.275, Florida Statutes, is created to read:

641.275 Examination of quality of health care services.—

(1) An examination of the quality of health care services provided by each health maintenance organization shall be performed by a peer review organization authorized by the department to conduct a review on behalf of the department. Examinations shall be performed at least once every 3 years under the direct supervision of the department.

(2) The results of any examination performed under this section is subject to evaluation by the department. The department must approve any examination results reported to it before the results are official.

(3) Notwithstanding s. 119.14, medical records of a subscriber or covered dependent that are maintained by a health maintenance organiza-

tion prior to October 1, 2001, are confidential and exempt from s. 119.07(1). However, appropriate disclosure may be made to the department or its agent for the purpose of evaluating the quality of the organization's health care services. To facilitate such an evaluation, each health maintenance organization shall provide to the department a procedure for the department to follow in obtaining records which are subject to review under this section. The department or its agent shall conduct record examinations in the least intrusive and disruptive manner and in a manner designed to maintain the confidential integrity of the documents handled. Any part of a record, or a copy thereof, may not be removed from the organization's offices without the department first obtaining a subpoena upon demonstration of good cause. Workpapers generated during the course of an examination are the property of the department.

(4) A health maintenance organization shall submit its administrative books and records to the department or its agent and take other appropriate action as necessary to facilitate an examination.

(5) For the purpose of implementing this section, the Insurance Commissioner or the department's general counsel may subpoena witnesses and compel their testimony, subpoena any medical records of a subscriber or covered dependent of a health maintenance organization, subpoena records of health care providers that are employed by or under contract with a health maintenance organization, and subpoena other evidence which is relevant to an examination. Records obtained pursuant to this subsection may be made available to department personnel or its agents.

(6) The department or its agent may administer oaths and examine health care providers that are employed by or under contract with a health maintenance organization and the officers and agents of an organization concerning its business and affairs relating to the quality of health care services being reviewed under this section. The reviewer acting under authority of this section shall report to the Insurance Commissioner the fact that a health maintenance organization has not complied with a request related to the review of medical records. The Insurance Commissioner may, in his discretion, suspend the certificate of authority issued to the health maintenance organization or impose any other penalty authorized under this part.

(7) If any person refuses to comply with any subpoena issued under this section or refuses to testify as to any matter concerning that which he may be lawfully interrogated, the circuit court of Leon County, the county wherein the examination is being conducted, or the county wherein the person resides, may, on the application of the department, issue an order requiring the person to comply with the subpoena and to testify. If the department prevails, all costs incurred by the department shall be paid by the health maintenance organization.

(8) The examination report and workpapers generated by the department or its agent under this section may only be used by the department in enforcing the requirements of this section and in disciplinary proceedings. Notwithstanding s. 119.14, reports and workpapers produced prior to October 1, 2001, pursuant to an examination are confidential and exempt from s. 119.07(1). These reports and workpapers may not be obtained from the department through discovery or subpoena in a civil action. The exemptions from s. 119.07(1) provided in this section are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(9) Any employee of the department or any employee of an agent of the department conducting an examination under this section who discloses information obtained during an examination to any person who is not directly responsible for implementing this section or disciplinary proceedings of the department is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(10) The expenses incurred by the peer review organization in examining a health maintenance organization shall be paid by the health maintenance organization.

(11) Information and documents required under s. 641.21 shall be maintained by each health maintenance organization and shall be available for inspection by the department at the offices of the organization during regular business hours. The department shall give reasonable notice to a health maintenance organization prior to any onsite examination conducted pursuant to this section.

Section 58. A health maintenance organization that provides health care services under a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services, prior to October 1, 1991, is subject to review under section 641.275, Florida Statutes, as determined appropriate by the Department of Insurance, but not later than 3 years after the date of the most recent renewal of its Health Care Provider Certificate by the Department of Health and Rehabilitative Services.

Section 59. Section 641.28, Florida Statutes, is amended to read:

641.28 Civil remedy.—In any civil action brought to enforce the terms and conditions of a health maintenance organization contract, the prevailing party is entitled to recover reasonable attorney's fees and court costs. This section *does* ~~shall~~ not ~~be construed to~~ authorize a civil action against the department, its employees, or the Insurance Commissioner ~~or against the Department of Health and Rehabilitative Services, its employees, or the secretary of that department~~.

Section 60. Section 641.29, Florida Statutes, is amended to read:

641.29 Fees, *assessments, and administrative penalties.*—

(1) Every health maintenance organization shall pay to the department the following fees *and assessments*:

(a)~~(1)~~ For filing a copy of its application for a certificate of authority or amendment thereto, a nonrefundable fee in the amount of $1,000.

(b)~~(2)~~ For filing each annual report, $150.

(c) An annual assessment not to exceed 0.1 percent of the gross amount of prepaid fees or premiums collected during the preceding calendar year by each health maintenance organization from contracts or certificates issued to subscribers in this state. The assessment is payable annually on or before February 1 and proceeds from the assessment shall be deposited into the Health Care Services Trust Fund established under s. 641.295.

1. The department shall:

a. On or before December 1 of each year, determine the amount of gross prepaid fees or premiums to which the assessment shall be applied for each health maintenance organization;

b. Determine the assessment percentage applicable to that calendar year;

c. On or before December 15 of each year, issue an order setting the assessment percentage for that calendar year; and

d. Mail a copy of the order to each health maintenance organization.

2. If, at the end of any fiscal year, an unencumbered balance of funds received from the assessment imposed under this section and s. 641.412 remains in the Health Care Services Trust Fund, such balance may not revert to the General Revenue Fund, but shall be retained in the Health Care Services Trust Fund to be used to defray the expenses of the department in discharging its administrative and regulatory powers and duties prescribed in this part, including the costs of maintaining offices; purchasing necessary equipment, supplies, and materials; paying personnel salaries and expenses; and funding all other expenses pertaining to regulating the quality of health care services offered by health maintenance organizations.

(2) Administrative penalties imposed by the department for a violation of any requirement imposed under this part relating to the quality of health care services shall be deposited into the Health Care Services Trust Fund.

Section 61. Section 641.295, Florida Statutes, is created to read:

641.295 Health Care Services Trust Fund.—There is established the Health Care Services Trust Fund to be administered by the Department of Insurance and used for the purpose of regulating the quality of health care services provided by health maintenance organizations and prepaid health clinics.

Section 62. All unencumbered funds in the Health Maintenance Organization Quality Care Trust Fund of the Department of Health and Rehabilitative Services on October 1, 1991, are transferred to the Health Care Services Trust Fund.

Section 63. Subsection (5) is added to section 641.30, Florida Statutes, to read:

641.30 Construction and relationship to other laws.—

(5) Part I of chapter 395 does not apply to a health maintenance organization if, on or before January 1, 1991, the organization does not provide more than 10 holding beds for short-term and hospice-type patients in an ambulatory care facility for its members, and the organization maintains current accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC).

Section 64. Section 641.51, Florida Statutes, is transferred, renumbered as section 641.3010, Florida Statutes, and amended to read:

641.3010 ~~641.51~~ Quality assurance program; *right to a* second medical opinion ~~requirement~~.—

(1) The organization shall ensure that the health care services provided to subscribers *are* ~~shall be~~ rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community.

(2) Each organization shall have an ongoing internal quality assurance program for its health care services. The program shall include, but not be limited to, the following:

(a) A written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;

(b) A written statement describing how state of the art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(c) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided;

(d) A written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization and periodic review by an external review organization not less frequently than once every 3 years.

(3) The professional judgment of a *provider* ~~physician~~ licensed under chapter 458, ~~or~~ chapter 459, *chapter 460, or chapter 461* concerning the proper course of treatment of a subscriber *is* ~~shall~~ not ~~be~~ subject to modification by the organization or its board of directors, officers, or administrators, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. However, this subsection *does* ~~shall~~ not ~~be considered to~~ restrict a utilization management program established by an organization.

(4) Each organization shall give the subscriber the right to a second medical opinion in any instance in which the subscriber disputes the organization's opinion of the reasonableness or necessity of surgical procedures or is subject to a life threatening injury or illness. The second opinion, if requested, is to be provided by a physician chosen by the subscriber. For second opinions provided by a noncontract physician, the subscriber must use a physician located in the same geographical service area of the organization. For second opinions provided by contract physicians, the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the organization, but may require the subscriber to be responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a noncontract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section *if* ~~in the event~~ the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber has unreasonably overutilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in *s.* ~~ss. 641.495 and~~ 641.311. The organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion *is* ~~shall be~~ controlling as to the treatment obligations of the health maintenance organization. Treatment not authorized by the health maintenance organization *is* ~~shall be~~ at the subscriber's expense.

Section 65. Section 641.55, Florida Statutes, is transferred, renumbered as section 641.3015, Florida Statutes, and amended to read:

641.3015 ~~641.55~~ Internal risk management program.—

(1) Every health maintenance organization certified under this part shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

(b) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including risk management and risk prevention education and training of all nonphysician personnel as follows:

1. Such education and training of all nonphysician personnel as part of their initial orientation; and

2. At least 1 hour of such education and training annually for all nonphysician personnel of the health maintenance organization who work in clinical areas and provide patient care;

(c) The analysis of patient grievances which relate to patient care and the quality of medical services; and

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all providers and all agents and employees of the health maintenance organization to report injuries and adverse incidents to the risk manager.

(2) The risk management program shall be the responsibility of the governing authority or board of the health maintenance organization. Every health maintenance organization which has an annual premium volume of $10 million or more and which directly provides health care in a building owned or leased by the health maintenance organization shall hire a risk manager, certified under ss. 626.941-626.945, who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager *may* ~~shall~~ not be responsible for risk management programs in more than four organizations or facilities. Every health maintenance organization which does not directly provide health care in a building owned or leased by the health maintenance organization and every health maintenance organization with an annual premium volume of less than $10 million shall designate an officer or employee of the health maintenance organization to serve as the risk manager.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Additional approaches may include extending risk management programs to provider offices or facilities.

(4) ~~The Department of Health and Rehabilitative Services shall, after consulting with~~ The Department of Insurance *shall adopt*, ~~promulgate~~ rules necessary to carry out the provisions of this section, including rules governing the establishment of required internal risk management programs to meet the needs of individual establishments. ~~The Department of Insurance shall assist~~ The Department of Health and Rehabilitative Services *shall assist the Department of Insurance* in preparing these rules. Each internal risk management program shall include the use of incident reports to be filed with the risk manager. The risk manager shall have free access to all health maintenance organization or provider medical records. The incident reports shall be considered to be a part of the workpapers of the attorney defending the establishment in litigation relating thereto and shall be subject to discovery, but not be admissible as evidence in court, nor shall any person filing an incident report be subject to civil suit by virtue of the incident report and the matters it contains. As a part of each internal risk management program, the incident reports shall be utilized to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct these problem areas.

(5)(a) Each health maintenance organization subject to this section shall submit an annual report to the department ~~of Health and Rehabilitative Services~~ summarizing the incident reports that have been filed in the health maintenance organization for that year pertaining to services rendered on the premises of the health maintenance organization. The report shall be on a form prescribed by rule of the department ~~of Health and Rehabilitative Services~~ and shall include with respect to medical services rendered on the premises of the health maintenance organization:

1. The total number of adverse incidents causing injury to patients.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. The name of each provider or a code number utilizing the health care professional's license number and a separate code number identifying all other individuals directly involved in adverse incidents causing injury to patients, the relationship of the individual or provider to the health maintenance organization, and the number of incidents in which each individual or provider has been directly involved. Each health maintenance organization shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all medical malpractice claims filed against the health maintenance organization or its providers, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.

6. A report of all disciplinary actions taken against any provider or any medical staff member of the health maintenance organization, including the nature and cause of the action.

(b) The information reported to the department pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, *chapter 460,* chapter 461, or chapter 466 shall also be reported to the Department of Professional Regulation quarterly. The Department of Professional Regulation shall review the information and determine whether any of the incidents potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(c) The annual report shall also contain the name of the risk manager of the health maintenance organization, a copy of its policy and procedures which govern the measures taken by the organization and its risk manager to reduce the risk of injuries and adverse or untoward incidents, and the results of these measures. *Notwithstanding s. 119.14, the annual* ~~This~~ report and the quarterly reports under paragraph (b) *submitted to the department, prior to October 1, 2001, are* ~~shall be held~~ confidential and *exempt from s. 119.07(1).* ~~shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, nor shall~~ The *annual* report *and quarterly reports are not* ~~be~~ discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board. *The annual report and quarterly reports may* ~~This report shall~~ not be *made* available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department, the Department of Professional Regulation, or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause. *The exemption from s. 119.07(1) provided in this subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.14.*

(6) If an adverse or untoward incident, whether occurring in the facilities of the health maintenance organization or arising from health care prior to admission to the facilities of the organization or in the facility of one of its providers, results in:

(a) The death of a patient;

(b) Severe brain or spinal damage to a patient;

(c) A surgical procedure being performed on the wrong patient; or

(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient,

the organization shall report this incident to the department ~~of Health and Rehabilitative Services~~ within 3 working days *after* ~~of~~ its occurrence. A more detailed follow-up report shall be submitted to the department ~~of Health and Rehabilitative Services~~ within 10 days after the first report. The department may require an additional, final report. Reports under this subsection shall be sent immediately by the department to the Department of Professional Regulation whenever they involve a health care provider licensed under chapter 458, chapter 459, *chapter 460,* chapter 461, or chapter 466. *Notwithstanding s. 119.14,* ~~These~~ reports *submitted to the department, prior to October 1, 2001, under this subsection may* ~~shall~~ not be *made* available to the public pursuant to *s. 119.07(1); are not* ~~s. 119.07 or any other law providing access to public records, nor be~~ discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board; *and may not,* ~~nor shall they~~ be *made* available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department, the Department of Professional Regulation, or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause. *The exemption from s. 119.07(1) provided in this subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.14.* The department ~~of Health and Rehabilitative Services~~ may investigate, as it deems appropriate, any *adverse or untoward* ~~such~~ incident and prescribe measures that must or may be taken by the health maintenance organization in response to the incident. The Department of Professional Regulation shall review each incident and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. The gross data compiled pursuant to this section or s. 395.041 shall be furnished by the department ~~of Health and Rehabilitative Services~~ upon request to health maintenance organizations to be utilized for risk management purposes. The department may *adopt* ~~promulgate~~ rules necessary to carry out the provisions of this section.

(7) In addition to any penalty imposed pursuant to *s. 641.23* ~~s. 641.52~~, the department may~~, beginning July 1, 1989,~~ impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of subsection (5) or subsection (6).

(8) The department and, upon subpoena issued pursuant to s. 455.223, the Department of Professional Regulation shall have access to all health maintenance organization records necessary to carry out the provisions of this section. *Notwithstanding s. 119.14,* the records obtained *by the department and the Department of Professional Regulation, prior to October 1, 2001, are exempt from s. 119.07(1),* are not available to *the* public, *and* ~~access, nor~~ are *not* ~~they~~ discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory board. *Notwithstanding s. 119.14,*; ~~nor may~~ records obtained pursuant to s. 455.223, *prior to October 1, 2001, are exempt from s. 119.07(1) and may not* be *made* available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records that form the basis of the determination of probable cause, except that, with respect to medical review committee records, the provisions of s. 766.101 control. *The exemptions from s. 119.07(1) provided in this subsection are subject to the Open Government Sunset Review Act in accordance with s. 119.14.*

(9) The department shall review, no less frequently than annually, the risk management program of each health maintenance organization regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5) and (6).

(10) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager certified under part IX of chapter 626 for the implementation and oversight of the risk

management program in a health maintenance organization authorized under this *part* ~~chapter~~ for any act or proceeding undertaken or performed within the scope of the function of such risk management program if the risk manager acts without intentional fraud.

(11) If the department, through its receipt of the annual reports prescribed in subsection (5) or through any investigation, has a reasonable belief that conduct by a provider, staff member, or employee of a health maintenance organization may constitute grounds for disciplinary action by the appropriate regulatory board, the department shall report this fact to the regulatory board.

(12) The department shall send information bulletins to all health maintenance organizations as necessary to disseminate trends and preventive data derived from its actions under this section or under s. 395.041.

The gross data compiled pursuant to this section or s. 395.041 shall be furnished by the department upon request to health maintenance organizations to be utilized for risk management purposes. The department may *adopt* ~~promulgate~~ rules necessary to carry out the provisions of this section.

Section 66. Section 641.54, Florida Statutes, is transferred and renumbered as section 641.3020, Florida Statutes.

Section 67. Subsection (5) of section 641.31, Florida Statutes, 1990 Supplement, is amended to read:

641.31 Health maintenance contracts.—

(5) Every subscriber shall receive a clear and understandable description of the method of the health maintenance organization for resolving subscriber grievances, and the method shall be set forth in the contract, certificate, and member handbook. *The organization shall also furnish each subscriber with a separate and additional communication notifying him of the existence of and his rights under the entire grievance process under s. 641.31085. The health maintenance organization shall meet the requirements of this provision by publishing this communication in the subscriber's health maintenance organization's newsletter and member handbook. A document stating the grievance process shall also be posted in the health maintenance organization's clinics and the off-site medical offices of each primary care physician operating under a contract with the organization.*

Section 68. Section 641.31085, Florida Statutes, is created to read:

641.31085 Subscriber grievance procedure.—

(1) Each health maintenance organization shall have a written grievance procedure for prompt and effective resolution of subscriber grievances. For purposes of initiating the formal grievance process, a complaint must be in written form. The organization shall advise and assist the subscriber as to the procedure necessary to convert a complaint into a formal grievance.

(2) The subscriber grievance procedure must include the following elements:

(a) There shall be an initial level of investigation and review of any grievance.

1. The initial review shall be conducted by a committee consisting of one or more individuals who may be employees of the health maintenance organization.

2. The initial review shall provide the opportunity for the subscriber and any other interested party to present written data pertinent to the grievance.

3. The decision of the initial review committee is binding unless the subscriber appeals the decision.

4. The subscriber shall be notified in writing of his right to appeal the decision to a second-level review committee.

(b) A subscriber has the right to appeal a decision of the initial review committee to a second level of review.

1. The second level of review shall be conducted by a committee established by the board of directors of the health maintenance organization.

2. At least one-third of the members of the committee must be subscribers of the health maintenance organization.

3. The decision of the second-level review committee is binding unless the subscriber appeals the decision to the department.

4. The subscriber shall be notified in writing of the subscriber's right to appeal a decision of the second-level review committee.

5. The second-level review committee shall have written procedures for investigating grievances, for conducting formal hearings, and for using informed consultants to resolve grievances.

(3) The health maintenance organization shall specify reasonable time limits for disposing of grievances at each level of review.

(4) At any stage of the grievance process, a subscriber may request and the health maintenance organization shall appoint a member of the staff who has no direct involvement in the case to represent the subscriber. A subscriber presenting a grievance shall be specifically notified of his rights to have a staff member appointed to assist him.

(5) The health maintenance organization shall maintain records of all grievances and shall include in its annual reports to the department a description of the total number of grievances handled, a compilation of the cases underlying the grievances, and the resolution of the grievances.

(6) The department shall investigate all reports of unresolved grievances received from appeals of subscribers whose grievances have not been satisfactorily resolved after the subscriber has followed the full grievance procedure of the organization.

(7) The department shall advise subscribers with grievances to follow the formal grievance process for resolution prior to review by the department.

(8) A grievance that remains unresolved after the subscriber has followed the full grievance procedure of the organization and the department has reviewed the grievance shall be presented to the Statewide Subscriber Assistance Program panel and addressed as set out in s. 641.311.

Section 69. Section 641.311, Florida Statutes, is amended to read:

641.311 Statewide Subscriber Assistance Program.—The department shall adopt and implement a program to provide assistance to subscribers, including those whose grievances are not satisfactorily resolved by the health maintenance organization. The program shall include the following:

(1)(a) A review panel which may periodically review, consider, and recommend to the department any actions the department should take concerning individual cases heard by the panel as well as the types of subscriber grievances which have not been satisfactorily resolved after the subscribers follow the full grievance procedures of the health maintenance organizations. The proceedings of the grievance panel shall not be subject to the provisions of chapter 120. The review panel shall consist of members employed by the department and members employed by the Department of Health and Rehabilitative Services, chosen by their respective agencies. *The department shall enter into a contract with a medical director and a primary care physician to provide additional technical expertise to the review panel. The medical director shall be selected from an accredited health maintenance organization.* ~~Outside qualified, impartial consultants may be consulted in connection with the types of grievances outside the expertise of the review panel.~~

(b) Every health maintenance organization shall submit a quarterly report to the department listing the number and the nature of all subscribers' grievances which have not been resolved to the satisfaction of the subscriber after the subscriber follows the full grievance procedure of the organization.

(2) A plan to disseminate information concerning the program to the general public as widely as possible.

Section 70. Subsection (3) of section 641.401, Florida Statutes, is amended to read:

641.401 Declaration of legislative intent, findings, and purposes.—

(3) It is the purpose of this part to:

(a) Minimize legal barriers to the organization, promotion, and expansion of prepaid health clinics.

(b) Recognize an exemption for prepaid health clinics, when operating under a subsisting certificate of authority issued pursuant to this part, from the operation of the Florida Insurance Code, as defined in s. 624.01, except in the manner and to the extent set forth in this part.

(c) Ensure that prepaid health clinics deliver high-quality health care.

Section 71. Present subsections (3), (4), (5), (6), (7), (8), (9), (10), and (11) of section 641.402, Florida Statutes, are redesignated as subsections (4), (5), (6), (7), (8), (9), (10), (11), and (12), respectively, and a new subsection (3) is added to that section, to read:

641.402 Definitions.—As used in this part, the term:

(3) "Geographic area" means the county or counties, or any portion of a county or counties, within which the prepaid health clinic provides or arranges for basic health care services to be available to its subscribers.

Section 72. Section 641.405, Florida Statutes, is amended to read:

641.405 Application for certificate of authority to operate prepaid health clinic.—

(1) *A* ~~No~~ person may *not* operate a prepaid health clinic without first obtaining a certificate of authority from the department. ~~The department shall not issue a certificate of authority to any applicant which does not possess a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services.~~

(2) Each application for a certificate of authority shall be on such form as the department prescribes, and such application shall be accompanied by:

(a) A copy of the basic organizational document of the applicant, if any, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable document, and all amendments to such document.

(b) A copy of the constitution, bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant.

(c) A list of the names, addresses, and official capacities with the applicant of the persons who are to be responsible for the conduct of the affairs of the clinic, including all members of the governing body, the officers and directors in the case of a corporation, and the partners or associates in the case of a partnership or association. Such persons shall fully disclose to the department and the governing body of the clinic the extent and nature of any contracts or arrangements between them and the clinic, including any possible conflicts of interest.

(d) A statement generally describing the clinic and its operations.

(e) A statement describing the manner in which health services shall be regularly available.

(f) The locations of the facilities at which health care services shall be regularly available to subscribers.

(g) The type of health care personnel engaged to provide the health care services and the quantity of the personnel of each type.

(h) A statement giving the present and projected number of subscribers to be enrolled yearly for the next 3 years.

(i) A statement indicating the source of emergency care on a 24-hour basis.

(j) A statement that the physicians employed by the applicant have been formally organized as a medical staff and that the applicant's governing body has designated a chief of medical staff.

(k) A statement describing the manner in which the clinic assures the maintenance of a medical records system in accordance with accepted medical records' standards and practices.

(l) If general anesthesia is to be administered in a facility not licensed by the Department of Health and Rehabilitative Services, a copy of architectural plans to meet the requirements for institutional occupancy (NFPA 101 Life Safety Code, current edition as adopted by the State Fire Marshal).

(m) A description of the clinic's quality assurance program, including committee structure, criteria, and procedures for corrective action which complies with s. 641.4187.

(n)~~(e)~~ *Forms* ~~Each form~~ of *all* prepaid health clinic *contracts* ~~contract~~ that the applicant proposes to offer the subscribers, showing for each form of contract the benefits to which the subscribers are entitled, together with a table of the rates charged, or proposed to be charged.

~~(f) A copy of the applicant's Health Care Provider Certificate from the Department of Health and Rehabilitative Services, issued pursuant to part IV of this chapter.~~

(o)~~(g)~~ A financial statement prepared on the basis of generally accepted accounting principles, except that surplus notes acceptable to the department may be included in the calculation of surplus.

(3) Any person or entity which enters into a contract with the Department of Health and Rehabilitative Services on a prepaid per capita or prepaid aggregate fixed-sum basis for the provision of health care services or social services, or both, to persons determined eligible for such services is exempt from this part and shall be governed by the standards set forth by the Department of Health and Rehabilitative Services unless the person or entity provides health care service on a prepaid basis to persons other than those for which the Department of Health and Rehabilitative Services has contracted. However, any person or entity which is not certificated under this part may not use in its name, logo, contracts, or literature the phrase "prepaid health clinic" or the initials "PHC"; imply, directly or indirectly, that it is a prepaid health clinic; or hold itself out to be a prepaid health clinic. Subject to these restrictions, any such person or entity may advertise and market their prepaid health or social services using words or phrases similar to "prepaid health services" or "prepaid social services," so long as the services are accurately described and the advertisement and marketing literature clearly discloses that such services are available only to persons eligible for health care or social services through the Department of Health and Rehabilitative Services. The Department of Health and Rehabilitative Services shall set standards and adopt rules in accordance with the Medicaid program and provisions in chapter 409 for conducting a prepaid plan which is exempt under this subsection.

Section 73. Section 641.406, Florida Statutes, is amended to read:

641.406 Issuance of certificate of authority.—The department shall issue a certificate of authority for a prepaid health clinic to any applicant filing a properly completed application in conformity with s. 641.405, upon payment of the prescribed fees and upon the department's being satisfied that:

~~(1) As a condition precedent to the issuance of any certificate, the applicant has obtained a Health Care Provider Certificate from the Department of Health and Rehabilitative Services pursuant to part IV of this chapter.~~

(1)~~(2)~~ The proposed rates are actuarially sound for the benefits provided, including administrative costs.

(2)~~(3)~~ The applicant has met the minimum surplus requirements of s. 641.407.

(3)~~(4)~~ The procedures for offering basic services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, health, or economic status. However, this subsection does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit experience rating.

(4)~~(5)~~ The procedures for offering basic services and offering and terminating contracts to subscribers will not discriminate on the basis of sex, race, or national origin.

(5)~~(6)~~ The applicant furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of basic services.

(6)~~(7)~~ The ownership, control, or management of the applicant is competent and trustworthy and possesses managerial experience that would make the proposed clinic operation beneficial to the subscribers. The department *may* ~~shall~~ not grant or continue authority to transact the business of a prepaid health clinic in this state at any time during which the department has good reason to believe that the ownership, control, or management of the clinic is under the control of any person whose busi-

ness operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; by the improper manipulation of assets or of accounts; or by bad faith.

(7)~~(8)~~ The application and the applicant are in conformity with all requirements of this part.

(8) The applicant has the ability to provide care of a quality consistent with prevailing professional standards applicable to delivery of health care services. In making this determination, the department shall require the clinic to:

(a) Demonstrate its capability to provide health care services in the geographical area it services.

(b) Ensure that the health care services it provides to subscribers are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs.

(c) Exercise reasonable care in assuring that services provided are performed by providers who are licensed to provide such services.

(d) Have a system for verifying and examining the credentials of each of its providers. The clinic shall maintain in a central file the credentials, including a copy of the current Florida license, of each of its physicians.

(e) Establish standards and procedures reasonably necessary to maintain a readily accessible medical records system which is adequate to provide necessary information including an accurate documentation of all services provided for every enrolled person.

(f) Inform subscribers in contracts, certificates, and subscriber handbooks, when applicable, that certain types of described medical procedures and services may be provided by individuals who are not licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

Section 74. Section 641.412, Florida Statutes, is amended to read:

641.412 Fees, *assessments, and administrative penalties.*—

(1) Every prepaid health clinic shall pay to the department the following fees *and assessments*:

(a) For filing a copy of its application for a certificate of authority or an amendment to such certificate, a nonrefundable fee in the amount of $150.

(b) For filing each annual report, a fee in the amount of $150.

(c) An annual assessment not to exceed 0.1 percent of the gross amount of prepaid fees or premiums collected during the preceding calendar year by each prepaid health clinic from contracts issued to subscribers in this state. The assessment is payable annually on or before February 1 and proceeds from the assessment shall be deposited into the Health Care Services Trust Fund established under s. 641.295

1. The department shall:

a. On or before December 1 of each year, determine the amount of gross prepaid fees or premiums to which the assessment shall be applied for each prepaid health clinic;

b. Determine the assessment percentage applicable to that calendar year;

c. On or before December 15 of each year, issue an order setting the assessment percentage for that calendar year; and

d. Mail a copy of the order to each prepaid health clinic.

2. If, at the end of any fiscal year, an unencumbered balance of funds received from the assessment imposed under this section and s. 641.29 remains in the Health Care Services Trust Fund, such balance may not revert to the General Revenue Fund, but shall be retained in the Health Care Services Trust Fund to be used to defray the expenses of the department in discharging its administrative and regulatory powers and duties prescribed in this part, including the costs of maintaining offices; purchasing necessary equipment, supplies, and materials; paying personnel salaries and expenses; and funding all other expenses pertaining to regulating the quality of health care services offered by prepaid health clinics.

(2) Administrative penalties imposed by the department for a violation of any requirement imposed under this part relating to the quality of health care services shall be deposited into the Health Care Services Trust Fund.

~~(2) The fees charged under this section shall be distributed as follows:~~

~~(a) One-third of the total amount of fees shall be distributed to the Department of Health and Rehabilitative Services; and~~

~~(b) Two-thirds of the total amount of fees shall be distributed to the Department of Insurance.~~

Section 75. Section 641.4185, Florida Statutes, is created to read:

641.4185 Examination of quality of health care services.—

(1) An examination of the quality of health care services provided by each prepaid health clinic shall be performed by a peer review organization authorized by the department to conduct a review on behalf of the department. Examinations shall be performed at least once every 3 years under the direct supervision of the department.

(2) The results of any examination performed under this section is subject to evaluation by the department. The department must approve any examination results reported to it before the results are official.

(3) Notwithstanding s. 119.14, medical records of a subscriber or covered dependent that are maintained by a prepaid health clinic, prior to October 1, 2001, are confidential and exempt from s. 119.07(1). However, appropriate disclosure may be made to the department or its agent for the purpose of evaluating the quality of the clinic's health care services. To facilitate such an evaluation, each prepaid health clinic shall provide to the department a procedure for the department to follow in obtaining records which are subject to review under this section. The department or its agent shall conduct record examinations in the least intrusive and disruptive manner and in a manner designed to maintain the confidential integrity of the documents handled. Any part of a record, or a copy thereof, may not be removed from the clinic's offices without the department first obtaining a subpoena upon demonstration of good cause. Workpapers generated during the course of an examination are the property of the department.

(4) A prepaid health clinic shall submit its administrative books and records to the department or its agent and take other appropriate action as necessary to facilitate an examination.

(5) For the purpose of implementing this section, the Insurance Commissioner or the department's general counsel may subpoena witnesses and compel their testimony, subpoena any medical records of a subscriber or covered dependent of a prepaid health clinic, subpoena records of health care providers that are employed by or under contract with a prepaid health clinic, and subpoena other evidence which is relevant to an examination. Records obtained pursuant to this subsection may be made available to department personnel or its agents.

(6) The department or its agent may administer oaths and examine health care providers that are employed by or under contract with a prepaid health clinic and the officers and agents of a clinic concerning its business and affairs relating to the quality of health care services being reviewed under this section. The reviewer acting under authority of this section shall report to the Insurance Commissioner the fact that a prepaid health clinic has not complied with a request related to the review of medical records. The Insurance Commissioner may, in his discretion, suspend the certificate of authority issued to the prepaid health clinic or impose any other penalty authorized under this part.

(7) If any person refuses to comply with any subpoena issued under this section or refuses to testify as to any matter concerning that which he may be lawfully interrogated, the circuit court of Leon County, the county wherein the examination is being conducted, or the county wherein the person resides, may, on the application of the department, issue an order requiring the person to comply with the subpoena and to testify. If the department prevails, all costs incurred by the department shall be paid by the prepaid health clinic.

(8) The examination report and workpapers generated by the department or its agent under this section may only be used by the department in enforcing the requirements of this section and in disciplinary proceedings. Notwithstanding s. 119.14, reports and workpapers produced prior to October 1, 2001, pursuant to an examination are confidential and

exempt from s. 119.07(1). These reports and workpapers may not be obtained from the department through discovery or subpoena in a civil action. The exemptions from s. 119.07(1) provided in this section are subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(9) Any employee of the department or any employee of an agent of the department conducting an examination under this section who discloses information obtained during an examination to any person who is not directly responsible for implementing this section or disciplinary proceedings of the department is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(10) The expenses incurred by the peer review organization in examining a prepaid health clinic shall be paid by the clinic.

(11) Information and documents required under s. 641.405 shall be maintained by each prepaid health clinic and shall be available for inspection by the department at the offices of the clinic during regular business hours. The department shall give reasonable notice to a prepaid health clinic prior to any onsite examination conducted pursuant to this section.

Section 76. A prepaid health clinic that provides health care services under a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services, prior to October 1, 1991, is subject to review under section 641.4185, Florida Statutes, as determined appropriate by the Department of Insurance, but not later than 3 years after the date of the most recent renewal of its Health Care Provider Certificate by the Department of Health and Rehabilitative Services.

Section 77. Section 641.4187, Florida Statutes, is created to read:

641.4187 Quality assurance program; right to second medical opinion.—

(1) The prepaid health clinic shall ensure that the health care services provided to subscribers are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community.

(2) Each prepaid health clinic shall have an ongoing internal quality assurance program for its health care services. The program shall include, but not be limited to, the following:

(a) A written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;

(b) A written statement describing how state of the art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(c) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided;

(d) A written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the prepaid health clinic and periodic review by an external review organization not less frequently than once every 3 years.

(3) The professional judgment of a provider licensed under chapter 458, chapter 459, chapter 460, or chapter 461 concerning the proper course of treatment of a subscriber is not subject to modification by the organization or its board of directors, officers, or administrators, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. However, this subsection does not restrict a utilization management program established by an organization.

(4) Each prepaid health clinic shall give the subscriber the right to a second medical opinion in any instance in which the subscriber disputes the prepaid health clinic's opinion of the reasonableness or necessity of surgical procedures or is subject to a life threatening injury or illness. The second opinion, if requested, is to be provided by a physician chosen by the subscriber. For second opinions provided by a noncontract physician, the subscriber must use a physician located in the same geographical service area of the organization. For second opinions provided by contract physicians, the prepaid health clinic is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The prepaid health clinic shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the prepaid health clinic, but may require the subscriber to be responsible for up to 40 percent of such amount. The prepaid health clinic may require that any tests deemed necessary by a noncontract physician shall be conducted by the prepaid health clinic. The prepaid health clinic may deny reimbursement rights granted under this section if the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the prepaid health clinic to be evidence that the subscriber has unreasonably overutilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in s. 641.311. The clinic's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion is controlling as to the treatment obligations of the prepaid health clinic. Treatment not authorized by the prepaid health clinic is at the subscriber's expense.

Section 78. Section 641.45, Florida Statutes, is amended to read:

641.45 Revocation ~~or cancellation~~ of certificate of authority; suspension of authority to enroll new subscribers; terms of suspension.—

~~(1) The maintenance of a valid and current Health Care Provider Certificate issued pursuant to part IV of this chapter is a condition of the maintenance of a valid and current certificate of authority issued by the department to operate a prepaid health clinic. Revocation or nonrenewal of a Health Care Provider Certificate shall be deemed to be an automatic and immediate cancellation of a prepaid health clinic's certificate of authority.~~

(1)~~(2)~~ The department may suspend the authority of a clinic to enroll new subscribers or revoke any certificate of authority issued to a prepaid health clinic, or order compliance within *30* ~~60~~ days, if the department finds that any of the following conditions exist:

(a) The clinic is not operating in compliance with this part or any rule promulgated under this part.

(b) The plan is no longer actuarially sound or the clinic does not have the minimum surplus as required by this part.

(c) The existing contract rates are excessive, inadequate, or unfairly discriminatory.

(d) The clinic has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for services or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(e) The *clinic* ~~organization~~ is insolvent.

(f) The clinic has refused to be examined pursuant to s. 641.4185, produce its accounts, records, and files for examination, or perform any other legal obligation as to such examination, when required by the department.

(g)~~(f)~~ The clinic has not complied with the grievance procedures for subscribers that are set forth in any prepaid health clinic contract.

(h)~~(g)~~ The clinic has not fully satisfied a judgment against the clinic within 10 days *after* ~~of~~ the entry of the judgment by any court in the state or, in the case of an appeal from such judgment, has not fully satisfied the judgment within 60 days after affirmance of the judgment by the appellate court.

(2)~~(3)~~ The department shall, in its order suspending the authority of a clinic to enroll new subscribers, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the clinic prior to reinstatement of its authority to enroll new subscribers. The order of suspension is subject to rescission or modification by further order of the department prior to the expiration of the suspension period. Reinstatement *may* ~~shall~~ not be made unless requested by the clinic; however, the department *may* ~~shall~~ not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(3) Revocation of a prepaid health clinic's certificate of authority shall be for a period of 2 years. After 2 years, the clinic may apply for a new certificate by complying with all application requirements applicable to first-time applicants.

Section 79. Section 641.455, Florida Statutes, is amended to read:

641.455 Disposition of moneys collected under this part.—

(1) ~~Fees,~~ Administrative penalties~~, examination expenses,~~ and other sums collected by the department under this part, *except as provided in subsection (2),* shall be deposited to the credit of the Insurance Commissioner's Regulatory Trust Fund~~; however, fees, examination expenses, and other sums collected by, or allocated to, the Department of Health and Rehabilitative Services under this part shall be deposited to the credit of the General Revenue Fund~~.

(2) Assessments, fees, and examination expenses collected under s. 641.412 or s. 641.4185 shall be deposited in the Health Care Services Trust Fund established under s. 641.295 and shall be used to defray the expenses of the department in discharging its administrative and regulatory powers and duties, including, the costs of maintaining offices, purchasing necessary supplies and equipment, paying personnel salaries and expenses, and funding all other expenses relating to regulating the quality of health care services provided under this part

Section 80. (1) The Division of Insurer Services of the Department of Insurance is allocated nine career service positions and one select exempt service position to carry out the provisions of this act.

(2) There is hereby appropriated from the Health Care Services Trust Fund of the Department of Insurance for fiscal year 1991-92 the sum of $1,050,545.

(3) There is hereby appropriated from the working capital trust fund of the Department of Insurance for fiscal year 1991-92 the sum of $330,000 for capital outlay.

Section 81. Rules adopted under the authority of part IV of chapter 641, Florida Statutes, prior to October 1, 1991, shall remain in effect and shall be administered by the Department of Insurance until such time as the Department of Insurance adopts rules pursuant to the transfer of health care service regulation to the Department of Insurance.

Section 82. All statutory powers, duties, records, and property under the control of the Department of Health and Rehabilitative Services pursuant to part IV of chapter 641, Florida Statutes, are hereby transferred by a type four transfer, as defined in section 20.06(4), Florida Statutes, to the Department of Insurance.

Section 83. The Health Care Cost Containment Board is directed to conduct a study on competition and provider contracts in health maintenance organizations.

(1) The board shall prepare and submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by December 15, 1991, a report addressing the following issues:

(a) The impact of competition, patient care, physician-patient relationships, and consumer choice on contract provisions which do not permit physicians to enter into contracts with other health maintenance organizations.

(b) The impact of competition, patient care, physician-patient relationships, and consumer choice on contract provisions which require a physician to make payment for liquidated damages when a physician terminates an agreement with a health maintenance organization and a subscriber elects to receive care from the same physician through another health maintenance organization.

(2) The report shall contain recommendations for any changes in state requirements for health maintenance organization provider contracts.

(3) The board shall appoint a technical advisory panel to conduct the study, which shall have representation from the following groups:

(a) A representative of elderly health care consumers.

(b) A representative of the physician community.

(c) Two representatives of the health maintenance organization industry.

(d) The Secretary of Health and Rehabilitative Services or his designee.

(e) The Commissioner of Insurance or his designee.

(f) A representative of the hospital industry.

(4) The board may procure information and assistance from any officer or agency of the state or any subdivision thereof. All such officers and agencies shall give the board all relevant information and reasonable assistance on any matters of research within their knowledge and control.

Section 84. Sections 641.47, 641.48, and 641.49, Florida Statutes; section 641.495, Florida Statutes, as amended by section 1 of chapter 90-213, Laws of Florida; and sections 641.515, 641.52, 641.56, 641.57, and 641.58, Florida Statutes, are repealed.

Section 85. Notwithstanding the provisions of section 11.61, Florida Statutes, the Regulatory Sunset Act, section 809(1st) of chapter 82-243, Laws of Florida, section 11 of chapter 84-313, Laws of Florida, section 47 of chapter 85-177, Laws of Florida, section 50 of chapter 85-321, Laws of Florida, section 17 of chapter 86-250, Laws of Florida, section 1 of chapter 86-286, Laws of Florida, section 4 of chapter 87-50, Laws of Florida, section 1 of chapter 88-303, Laws of Florida, section 54 of chapter 88-380, Laws of Florida, section 24 of chapter 88-388, Laws of Florida, or section 80 of chapter 89-360, Laws of Florida, sections 641.17, 641.18, 641.19, 641.201, 641.2015, 641.2017, 641.21, 641.22. 641.221, 641.225, 641.227, 641.228, 641.23, 641.234, 641.2342, 641.25, 641.255, 641.26, 641.261, 641.27, 641.28, 641.281, 641.282, 641.285, 641.286, 641.29, 641.30, 641.3005, 641.3007, 641.305, 641.31, 641.3101, 641.3102, 641.3103, 641.3104, 641.3105, 641.3106, 641.3107, 641.3108, 641.31085, 641.311, 641.3111, 641.315, 641.32, 641.33, 641.35, 641.36, 641.365, 641.37, 641.38, 641.386, 641.3901, 641.3903, 641.3905, 641.3907, 641.3909, 641.3911, 641.3913, 641.3917, 641.3921, 641.3922, 641.40, 641.401, 641.4015, 641.402, 641.403, 641.405, 641.406, 641.4065, 641.407, 641.408, 641.409, 641.4091, 641.41, 641.411, 641.412, 641.414, 641.416, 641.418, 641.419, 641.42, 641.421, 641.422, 641.423, 641.424, 641.425, 641.426, 641.427, 641.429, 641.43, 641.432, 641.437, 641.44, 641.441, 641.442, 641.443, 641.444, 641.445, 641.446, 641.447, 641.448, 641.45, 641.452, 641.453, 641.454, 641.455, 641.457, and 641.459, Florida Statutes, shall not stand repealed effective October 1, 1991, as scheduled by such laws, but such sections, as amended by this act, are revived and readopted.

Section 86. Sections 641.17, 641.18, 641.19, 641.201, 641.2015, 641.2017, 641.21, 641.22, 641.221, 641.225, 641.227, 641.228, 641.23, 641.234, 641.2342, 641.25, 641.255, 641.26, 641.261, 641.27, 641.275, 641.28, 641.281, 641.282, 641.285, 641.286, 641.29, 641.295, 641.30, 641.3005, 641.3007, 641.3010, 641.3015, 641.3020, 641.305, 641.31, 641.3101, 641.3102, 641.3103, 641.3104, 641.3105, 641.3106, 641.3107, 641.3108, 641.31085, 641.311, 641.3111, 641.315, 641.32, 641.33, 641.35, 641.36, 641.365, 641.37, 641.38, 641.385, 641.386, 641.3901, 641.3903, 641.3905, 641.3907, 641.3909, 641.3911, 641.3913, 641.3917, 641.3921, 641.3922, 641.40, 641.401, 641.4015, 641.402, 641.403, 641.405, 641.406, 641.4065, 641.407, 641.408, 641.409, 641.4091, 641.41, 641.411, 641.412, 641.414, 641.416, 641.418, 641.4185, 641.4187, 641.419, 641.42, 641.421, 641.422, 641.423, 641.424, 641.425, 641.426, 641.427, 641.429, 641.43, 641.432, 641.437, 641.44, 641.441, 641.442, 641.443, 641.444, 641.445, 641.446, 641.447, 641.448, 641.45, 641.452, 641.453, 641.454, 641.455, 641.457, and 641.459, Florida Statutes, are repealed effective October 1, 2001, and must be reviewed by the Legislature prior to that date pursuant to the Regulatory Sunset Act, section 11.61, Florida Statutes.

Section 87. Subsection (9) is added to section 186.003, Florida Statutes, to read:

186.003 Definitions.—As used in ss. 186.001-186.031 and 186.801-186.911, the term:

(9) "Statewide Health Council" means the Statewide Health Council established pursuant to s. 381.703.

Section 88. Subsection (2) of section 186.022, Florida Statutes, is amended to read:

186.022 State agency functional plans; consistency with state comprehensive plan.—

(2) The Executive Office of the Governor shall review the proposed state agency functional plans for consistency with the state *comprehensive* plan, and shall, within 60 days, return a proposed agency functional plan to the agency, together with any proposed revisions. *The Executive Office of the Governor shall consider the findings of the Statewide Health Council's review of the consistency of the health components of agency functional plans with the health element of the state comprehensive plan in formulating proposed revisions to the agency functional plans.*

Section 89. Present subsection (7) of section 186.503, Florida Statutes, is redesignated as subsection (8) of that section and a new subsection (7) and subsection (9) are added to that section to read:

186.503 Definitions.—As used in this act, the term:

(7) "Local health council" means a regional agency established pursuant to s. 381.703.

(9) "Statewide Health Council" means the Statewide Health Council established pursuant to s. 381.703.

Section 90. Subsection (10) is added to section 186.507, Florida Statutes, to read:

186.507 Comprehensive regional policy plans.—

(10) Each regional planning council shall enter into a memorandum of agreement with each local health council in its comprehensive planning district to ensure the coordination of health planning. The memorandum of agreement shall specify the manner in which each regional planning council and local health council will coordinate their activities.

Section 91. Subsection (1) of section 186.508, Florida Statutes, is amended to read:

186.508 Comprehensive regional policy plan adoption; consistency with state comprehensive plan.—

(1) Within 18 months of the adoption of the state comprehensive plan, each regional planning council shall submit to the Executive Office of the Governor its proposed comprehensive regional policy plan. The Executive Office of the Governor, or its designee, shall review the proposed comprehensive regional policy plan for consistency with the adopted state comprehensive plan and shall, within 90 days, return the proposed comprehensive regional policy plan to the council, together with any revisions recommended by the Governor. *The Executive Office of the Governor must consider the findings of the Statewide Health Council's review of the consistency of the health elements of the comprehensive regional policy plans with the health element of the state comprehensive plan in formulating recommended revisions to the comprehensive regional policy plans.* The Governor's recommended revisions shall be included in the plans in a comment section. However, nothing herein shall preclude a regional planning council from adopting or rejecting any or all of the revisions as a part of its plan prior to the effective date of the plan. The rules adopting the regional policy plan shall not be subject to rule challenge under s. 120.54(4) or to drawout proceedings under s. 120.54(17), but, once adopted, shall be subject to an invalidity challenge under s. 120.56 by substantially affected persons, including the Executive Office of the Governor. The rules shall be adopted by the regional planning councils by July 1, 1987, and shall become effective upon filing with the Department of State, notwithstanding the provisions of s. 120.54(13).

Section 92. Section 186.511, Florida Statutes, is amended to read:

186.511 Evaluation of comprehensive regional policy plan; changes in plan.—The regional planning process shall be a continuous and ongoing process. Each regional planning council shall prepare an evaluation report on its comprehensive regional policy plan at least once every 3 years; assess the successes or failures of the plan; and prepare and adopt by rule amendments, revisions, or updates to the plan as needed. *Each regional planning council shall involve the appropriate local health councils in its region in the review of the health element of its plan.*

Section 93. Subsection (6) of section 187.201, Florida Statutes, 1990 Supplement, is amended to read:

187.201 State Comprehensive Plan adopted.—The Legislature hereby adopts as the State Comprehensive Plan the following specific goals and policies:

(Substantial rewording of subsection. See s. 187.201(6), F.S., for present text.)

(6) HEALTH.—

(a)1. Goal.—Healthy residents who protect their own health and the health of others and who actively participate in recovering their own health when they become ill.

2. Policies.—

a. Individuals are fundamentally responsible for their own health, but they need encouragement and may need financial support from government.

b. The state shall develop mechanisms whereby all Florida residents can participate in a plan of adequate health care coverage to which they contribute financially, based on their ability to pay.

c. All Florida residents should be supported through education and other means to develop and maintain healthy lifestyles.

d. All Florida students should be provided with comprehensive, continuous health education in pre-Kindergarten through grade 12 settings.

e. Treatment of illness is a partnership between health care providers and patients in which individual patients participate in decisions related to their health care. In this process, patients and health care providers have mutual rights and responsibilities.

(b)1. Goal.—An environment which supports a healthy population and which does not cause illness.

2. Policies.—

a. Every Florida resident has a right to breathe clean air, drink pure water, and eat nutritious food.

b. The state should assure a safe and healthful environment through monitoring and regulating activities which impact the quality of the state's air, water, and food.

c. Government shall ensure that future growth does not cause the environment to adversely affect the health of the population.

d. Every employer shall provide a safe and healthful workplace.

(c)1. Goal.—Health care services which are of high quality, reasonably accessible, and adequate to meet the needs of the public.

2. Policies.—

a. Where feasible, resources will be redirected to programs and services that prevent illness and intervene in the early stages of disease.

b. The public shall have access to affordable health care.

c. Each pregnant woman in this state has a right to adequate prenatal care in order to protect her health and to help her child begin life healthy.

d. The state shall promote the availability of needed health care professionals and services in medically underserved areas.

e. The responsibility for ensuring good quality, accessibility, and availability of health care services is shared among health care practitioners, institutions, patients, and government.

f. Government shall provide for the orderly growth and development of health care facilities and services through health planning, growth management, and regulation.

g. Government shall establish a public health infrastructure of facilities, equipment, and personnel necessary to provide for community health needs.

(d)1. Goal.—Health costs which are contained to a level appropriate to the financial resources of the state and its residents.

2. Policies.—

a. The primary long-range strategy for containing health care costs shall be prevention of avoidable illness and disability.

b. The state shall promote the development of a rational financing system for health care which minimizes the shifting of costs, discourages inappropriate utilization, reduces administrative costs, and contains the costs of new technology.

c. The state shall encourage the delivery of health care services in a manner that enables patients to establish reasonable expectations of outcome and enables health care providers to focus on the health of their patients.

Section 94. Subsections (1), (2), and (4) of section 381.703, Florida Statutes, are amended to read:

381.703 Local and state health planning.—

(1) LOCAL HEALTH COUNCILS.—

(a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a district of the department. The members of each council shall be appointed in an equitable manner by the county commissions having jurisdiction in the respective district. Each council shall be composed of a number of persons equal to 1½ times the number of counties which compose the district or 12 members, whichever is greater. Each county in a district shall be entitled to at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population rounded to the nearest whole number; except that in a district composed of only two counties, no county shall have fewer than four members. ~~The department shall adopt a rule allocating membership of the various counties pursuant to this paragraph which designates the number of initial appointments from each county,~~ The appointees ~~who~~ shall be representatives of health care providers, health care purchasers, and nongovernmental health care consumers, but not excluding elected government officials~~, and which provides for an orderly rotation of the appointment of the various classifications of members among the counties in each district~~. The members of the consumer group shall include a representative number of persons over 60 years of age. A majority of council members shall consist of health care purchasers and health care consumers. *The local health council shall provide each county commission a schedule for appointing council members to ensure that council membership complies with the requirements of this paragraph.* The members of the local health council shall elect a chairman. Members shall serve for terms of 2 years and may be eligible for reappointment.

(b) Each local health council shall:

1. Develop a district *health* plan *which is consistent with the objectives and strategies in the state health plan, but*~~, using uniform methodology as set forth by the department,~~ which shall permit each local health council to develop *strategies and set priorities for implementation* ~~goals and criteria~~ based on its unique local health needs. *The district health plan must contain preferences for health services' and facilities' development which must be considered by the department in its review of certificate-of-need applications.* The district *health* plan shall be submitted to the department and updated periodically ~~and shall be in a form prescribed by the department~~. *The district health plans shall use a uniform format and be submitted to the department according to a schedule developed by the department in conjunction with the Statewide Health Council and the local health councils. The schedule must provide for coordination between the development of the state health plan and the district health plans and for the development of district health plans by major sections over a multiyear period.* The elements of a district plan which are necessary to the review of certificate-of-need applications for proposed projects within the district shall be adopted by the department as a part of its rules. ~~The district plan shall include, but need not be limited to:~~

~~a. The availability, quality of care, efficiency, appropriateness, accessibility, extent of utilization, and adequacy of existing health care facilities and services and hospices in the district.~~

~~b. The need, availability, and adequacy of other health care facilities and services and hospices in the district, including outpatient care and ambulatory or home care services, which may serve as less costly alternatives to proposed or available health care facilities and services.~~

~~c. The probable economies and improvements in services that may be derived from operation of joint, cooperative, or shared health care and health planning resources.~~

~~d. The need in the district for special equipment and services which are not reasonably and economically accessible in adjoining areas.~~

~~e. The need for research and educational facilities, including, but not limited to, institutional and community training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels, and for other health care practitioners.~~

~~f. A description of: the existing care and treatment network for persons with human immunodeficiency virus, acquired immune deficiency syndrome, and acquired immune deficiency syndrome related complex, as delineated in s. 381.612; an analysis of service and facility needs for the identified patient population; and recommendations on an annual basis to the department and the Legislature regarding additional service needs for such patients residing in the district.~~

~~2. Stimulate the development of cooperative arrangements relating to the health manpower training efforts of educational institutions and service institutions and the health manpower recruitment and retention efforts of medically underserved communities.~~

~~3. Identify and encourage community resources and mechanisms to facilitate consumer choice and market competition in health care by providing data, information, and analysis on charges, resource availability, and certification~~.

2.~~4.~~ Advise the district administrator of the department on health care *issues and* resource allocations~~, including federal block grant funds, and work with the district administrator; the district alcohol, drug abuse, and mental health planning councils; and the areawide agency on aging in developing and carrying out a health resources allocation plan~~.

3.~~5.~~ *Promote* ~~Implement activities to increase~~ public awareness of community health needs, *emphasizing health promotion* and ~~emphasize advantages of preventive health activities and~~ cost-effective health service selection.

4.~~6.~~ *Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and* assist the department *and other state agencies* in carrying out data collection activities that relate to the functions ~~set forth~~ in this subsection.

5.~~7.~~ Monitor the onsite construction progress, if any, of *certificate-of-need approved* projects and report *council* ~~their~~ findings to the department on forms provided by the department.

6. Advise and assist regional planning councils within each district with the development of the health element of the comprehensive regional policy plan to address the health goals and policies in the State Comprehensive Plan.

7.~~8.~~ Advise and assist ~~regional planning councils and~~ local governments within each ~~respective~~ district on the development of *an* optional *health* plan *element of the comprehensive plan provided in chapter 163, to assure compatibility with* ~~elements to address~~ the health goals and policies in the State Comprehensive Plan, *and district health plan. To facilitate the implementation of this section, the local health council shall annually provide the local governments in its service area, upon request, with:*

a. A copy and appropriate updates of the district health plan;

b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction; and

c. Applicable department rules and calculated need methodologies for health facilities and services regulated under s. 381.704 for the district served by the local health council.

8.~~9.~~ Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of *local,* state, *federal, and private* funds distributed to meet the needs of the medically indigent *and other underserved population groups.* ~~A report on indigent care shall be prepared by each local health council and submitted to the Statewide Health Council no later than January 1 of each year. At a minimum, the report shall include the following elements:~~

~~a. An inventory of services within the district providing health care to Medicaid and medically indigent clients.~~

~~b. An assessment of the use of those services by Medicaid and medically indigent clients.~~

~~c. An evaluation of the population need within the district for indigent health care services and a determination of whether or not that need is being met.~~

~~d. A summary presentation of public opinion in communities throughout the district on the needs of the medically indigent and the services provided to meet these needs.~~

~~e. Recommendations for improving health care services for the medically indigent.~~

9.~~10. Have the responsibility~~ In conjunction with the Department of Health and Rehabilitative Services and Statewide Health Council, *plan for* ~~of planning and coordinating~~ services at the local level for persons *infected* with *the* human immunodeficiency virus~~, acquired immune deficiency syndrome, and acquired immune deficiency syndrome related complex~~.

10. Provide technical assistance to encourage and support activities by providers, purchasers, consumers, and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

11. Provide the department with data required by rule for the review of certificate-of-need applications and the projection of need for health services and facilities in the district.

(c) Local health councils may conduct public hearings pursuant to s. 381.709(3)(b).

(d) Each local health council shall enter into a memorandum of agreement with each regional planning council in its district. In addition, each local health council shall enter into a memorandum of agreement with each local government that includes an optional health element in its comprehensive plan. Each memorandum of agreement must specify the manner in which each local government, regional planning council, and local health council will coordinate their activities to ensure a unified approach to health planning and implementation efforts.

(e)~~(d)~~ Local health councils may employ personnel to carry out the councils' purposes. Such personnel shall possess qualifications and be *compensated in a manner* ~~paid salaries~~ commensurate with comparable positions in the Career Service System. However, such personnel shall not be deemed to be state employees.

(f) Personnel of the local health councils shall provide an annual orientation to council members about council member responsibilities. The orientation shall include presentations and participation by department staff.

(g)~~(e)~~ Each local health council is authorized to accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources and to perform studies related to local health planning in exchange for such funds, grants, or services. Each local health council shall, no later than January 30 of each year, render an accounting of the receipt and disbursement of such funds received by it to the department. The department shall consolidate all such reports and submit such consolidated report to the Legislature no later than March 1 of each year. Funds received by a local health council pursuant to this paragraph shall not be deemed to be a substitute for, or an offset against, any funding provided pursuant to subsection (3).

(2) STATEWIDE HEALTH COUNCIL.—The Statewide Health Council is hereby established as a state-level comprehensive health *planning and policy advisory board. For administrative purposes, the council shall be located within* ~~council which is advisory to~~ the department. The Statewide Health Council shall be composed of: the *State Health Officer, the Deputy Secretary for Programs, the Assistant Secretary for Medicaid, and the Assistant Secretary for Regulation and Health Facilities of the department; the executive director of the Health Care Cost Containment Board; the Insurance Commissioner or his designee; the Vice Chancellor for Health Affairs of the Board of Regents; three chairmen of regional planning councils, selected by the regional planning councils; five* ~~11~~ chairmen of ~~the~~ local health councils, *selected by the local health councils; four* ~~two~~ members appointed by the Governor, *one of whom is a consumer over 60 years of age, one of whom is a representative of organized labor, one of whom is a physician, and one of whom represents the nursing home industry; five* ~~two~~ members appointed by the President of the Senate, *one of whom is a representative of the insurance industry in this state, one of whom is the chief executive officer of a business with more than 300 employees in this state, one of whom represents the hospital industry, one of whom is a primary care physician, and one of whom is a nurse,* and *five* ~~two~~ members appointed by the Speaker of the House of Representatives, *one of whom is a consumer who represents a minority group in this state, one of whom represents the home health care industry in this state, one of whom is an allied health care professional, one of whom is the chief executive officer of a business with fewer than 25 employees in this state, and one of whom represents a county social services program that provides health care services to the indigent.* ~~At least one of the two members appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives, respectively, shall be a health care consumer or a health care purchaser.~~ Appointed members of the council shall serve for ~~a~~ 2-year *terms* ~~term~~ commencing *October* ~~on January~~ 1 of each *even-numbered* ~~odd-numbered~~ year. *The council shall elect a president from among the members who are not state employees.* The Statewide Health Council shall:

(a) Advise the Governor, the Legislature, and the department on state health policy issues, state and local health planning activities, and state health regulation programs;

(b) Prepare a state health plan that specifies subgoals, quantifiable objectives, strategies, and resource requirements to implement the goals and policies of the health element of the State Comprehensive Plan. The plan must assess the health status of residents of this state; evaluate the adequacy, accessibility, and affordability of health services and facilities; assess government-financed programs and private health care insurance coverages; and address other topical local and state health care issues. Within 2 years after the health element of the State Comprehensive Plan is amended, and by July 1 of every 3rd year, if it is not amended, the Statewide Health Council shall submit the state health plan to the Executive Office of the Governor, the secretary of the department, the President of the Senate, and the Speaker of the House of Representatives;

(c)~~(b)~~ Promote public awareness of state health care issues *and, in conjunction with the local health councils, conduct public forums throughout the state to solicit the comments and advice of the public on the adequacy, accessibility, and affordability of health care services in this state and other health care issues;*

(d)~~(c)~~ Consult with local health councils, the Health Care Cost Containment Board, the Department of Insurance, the Department of Health and Rehabilitative Services, and other appropriate public and private entities, including health care industry representatives regarding the development of health policies;

(e) Serve as a forum for the discussion of local health planning issues of concern to the local health councils and regional planning councils;

(f)~~(d)~~ Review district health plans for consistency with *the* State *Comprehensive Plan and the state* health *plan* ~~goals and policies~~;

(g) Review the health components of agency functional plans for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to agency functional plans to make them consistent with the State Comprehensive Plan;

(h) Review the comprehensive regional plans for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to comprehensive regional policy plans to make them consistent with the State Comprehensive Plan;

~~(e) Prepare a state report, which includes the evaluations by each local health council for its respective district, on the adequacy, appropriateness, and effectiveness of state funds distributed to meet the needs of the medically indigent;~~

(i)~~(f)~~ Assist the Department of Community Affairs in the review of local government comprehensive plans to ensure consistency with policy developed in the district health plans;

(j) With the assistance of the local health councils, conduct public forums and use other means to determine the opinions of health care consumers, providers, payers, and insurers regarding the state's health care goals and policies and develop suggested revisions to the health element of the State Comprehensive Plan. The council shall submit the proposed revisions to the health element of the State Comprehensive Plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1993, and shall widely circulate the proposed revisions to affected parties. The council shall periodically assess the progress made in achieving the goals and policies contained in the health element of the State Comprehensive Plan and reporting to the department, the Governor, the President of the Senate, and the Speaker of the House of Representatives; and

(k)~~(g)~~ Conduct any other functions or studies and analyses falling under the *duties listed* ~~purview of the mission, goals, and objectives~~ above.~~; and~~

~~(h) Assist the local health councils in developing their analysis of service and facility needs for persons with acquired immune deficiency syndrome, acquired immune deficiency syndrome related complex, or human immunodeficiency virus infection within their district and advise the department on additional service needs for such persons in the state.~~

(4) DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT.—

(a) The department, *in conjunction with the Statewide Health Council and the local health councils,* is responsible for the planning of all health care services in the state and for *assisting the Statewide Health Council in* the preparation of the state health plan.

(b) The department shall develop and maintain a comprehensive health care data base for the purpose of health planning and for certificate-of-need determinations. The department or its contractor is authorized to require the submission of information from health facilities, health service providers, and licensed health professionals which is determined by the department, through rule, to be necessary for meeting the department's responsibilities as established in this section.

(c) The department shall assist personnel of the local health councils in providing an annual orientation to council members about council member responsibilities.

(d)~~(c)~~ The department shall *contract with* ~~provide funding for~~ the local health councils *for the services specified in subsection (1)* ~~according to an allocation plan~~. All contract funds shall be distributed according to an allocation plan developed by the department that provides for a minimum and equal funding base for each local health council. Any remaining funds shall be distributed based on adjustments for workload. The department may also make grants to or reimburse local health councils from federal funds provided to the state for activities related to those functions set forth in this section. *The department may withhold funds from a local health council or cancel its contract with a local health council which does not meet performance standards agreed upon by the department and local health councils.*

Section 95. Subsection (2) of section 401.291, Florida Statutes, 1990 Supplement, is amended to read:

401.291 Automatic external defibrillators.—

(2) An automatic or semiautomatic defibrillator may be used by any individual who meets the requirements of this section and who is a member of a locally coordinated response team which is authorized to respond to a request for emergency assistance for the purpose of providing an assessment of the need for and appropriate use of an automatic or semiautomatic defibrillator, provided such individual has successfully completed an appropriate training course as approved by the local emergency medical services medical director. This requirement shall consist of certification in cardiopulmonary resuscitation *or*~~,~~ successful completion of an 8-hour basic first-aid course *that includes cardiopulmonary resuscitation training,* demonstrated proficiency in the use of an automatic or semiautomatic defibrillator, and successful completion of at least 6 hours of training in at least two sessions, to include instruction in:

(a) The proper use, maintenance, and periodic inspection of the automatic or semiautomatic defibrillator.

(b) Defibrillator safety precautions to enable the user to administer a shock without jeopardizing the safety of the patient, the user, or other persons.

(c) Assessment of an unconscious person to determine if cardiac arrest has occurred and the appropriateness of applying an automatic or semiautomatic defibrillator.

(d) Recognizing that an electrical shock has been delivered to the patient and that the defibrillator is no longer charged.

(e) Rapid, accurate assessment of the patient's postshock status to determine if further activation of the automatic or semiautomatic defibrillator is necessary.

(f) The operations of the local emergency medical services system, including methods of access to the emergency response system, and interaction with emergency medical services personnel.

(g) The role of the user and coordination with other emergency medical service providers in the provision of cardiopulmonary resuscitation, defibrillation, basic life support, and advanced life support.

(h) The responsibility of the user to continue care until the arrival of medically qualified personnel.

Section 96. The sum of $70,000 is hereby appropriated from the Local and State Health Trust Fund to the Statewide Health Council for reviewing the agency functional plans and comprehensive regional policy plan for consistency with the health element of the state comprehensive plan, for the public hearings on the health element of the state comprehensive plan, and for staff support and expenses of the council.

Section 97. Section 381.025, Florida Statutes, is hereby repealed.

Section 98. Health Care 2000 Commission.—

(1) It is the intent of the Legislature to provide a means by which the state may develop a plan for organizing and financing a health care system which will by the year 2000:

(a) Assure access to adequate health care services to all residents of this state;

(b) Require all residents of this state to participate in a plan of adequate health care coverage; and

(c) Require all residents of this state to contribute, based on their ability to pay, to the financing of health care services.

(2) There is created within the Executive Office of the Governor the Health Care 2000 Commission, a planning commission for health care by the year 2000.

(a) The commission shall consist of 31 members who shall be appointed by August 1, 1991. The members shall be:

1. The Governor or Lieutenant Governor;

2. Three members of the Senate, appointed by the President of the Senate;

3. Three members of the House of Representatives, appointed by the Speaker of the House of Representatives;

4. The Commissioner of Insurance or his designee;

5. The Secretary of the Department of Health and Rehabilitative Services or his designee;

6. The Deputy Secretary for Health of the Department of Health and Rehabilitative Services;

7. The Assistant Secretary for Medicaid of the Department of Health and Rehabilitative Services;

8. The Secretary of the Department of Professional Regulation or his designee;

9. The Secretary of the Department of Labor and Employment Security or his designee;

10. The Chancellor of the State University System or his designee;

11. The Chairman of the Health Care Cost Containment Board;

12. The President of the Statewide Health Council;

13. The President of the Florida Medical Association;

14. The President of the Florida Nurses Association;

15. A representative of public hospitals in this state, appointed by the Florida Hospital Association;

16. A representative of voluntary hospitals in this state, appointed by the Association of Voluntary Hospitals of Florida;

17. A representative of the proprietary hospitals in this state, appointed by the Florida League of Hospitals;

18. Two representatives of statewide labor organizations, appointed by the Governor;

19. One chief executive officer of a business in this state that has more than 300 employees, appointed by the Governor;

20. One chief executive officer of a business in this state that has between 25 and 300 employees, appointed by the Governor;

21. One chief executive officer of a business in this state that has fewer than 25 employees, appointed by the Governor;

22. Two chief executive officers of insurance companies that are licensed and delivering products in this state, and that have substantial experience in health care, appointed by the Governor;

23. The Executive Director of the Florida Health Access Corporation;

24. A representative of the counties, appointed by the Florida Association of Counties; and

25. A representative of an organization representing the elderly, appointed by the Governor.

(b) The commission shall be chaired by the Governor or Lieutenant Governor and shall exist for 2 years. The commission shall meet as often as it deems necessary to carry out its duties and responsibilities.

(c) The commission shall prepare and submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by February 1, 1993, a plan and specific implementation recommendations to fulfill the requirements of subsection (1). In developing the plan and implementation recommendations, the commission shall address the following issues:

1. How can health care cost increases be brought under control?

2. What is the appropriate role for government regulation and regulatory programs? Should regulatory programs be changed to permit more flexibility for the health care delivery system to restructure itself to become more efficient?

3. What should be the financing mechanism for health care? What role should private health insurance play in financing health care?

4. Should the state continue to rely on employment based health care coverage as a means of assuring access to health care services?

5. How should health policy be developed? What is the most appropriate structure for data collection, issue analysis, and planning for health care?

6. How can the emphasis be placed on the prevention of illness and primary care in terms of how the health care delivery system is structured and where the dollars are spent?

7. What role should the state have in ensuring that adequate numbers of health care professionals are trained and available to provide needed health care services?

8. What role should the state have in evaluating new health care technology and promoting the use of new technology that reduces costs?

9. How can an acceptable level of quality for health care services be established and maintained?

10. How much is currently being spent for health care by Florida residents? How much will it cost to implement the plan and recommendations developed by the commission?

(d) The commission shall prepare and submit an interim report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1992, which shall propose any actions that should be taken during the 1992 legislative session to further the goals of the commission.

(e) The commission shall appoint an executive director to serve at its pleasure, who shall perform the duties assigned to him by the commission. The executive director shall be the chief administrative officer of the commission and shall, upon approval of the commission, be responsible for appointing all employees and staff members of the commission. Until such time as the commission has appointed its executive director, the commission shall receive staff and administrative support from the Executive Office of the Governor.

(f) The members of the commission shall serve without compensation, but shall be entitled to be reimbursed for per diem and travel expenses while engaged in commission duties, as provided in section 112.061, Florida Statutes.

(g) The commission may contract with one or more public or private organizations or individuals to perform such functions as are in keeping with the intent of this section.

(h) The commission created by this act is not an executive department or agency for purposes of assignment under s. 6 of Art. IV of the State Constitution, nor is it an agency within the legislative intent of chapter 216 or chapter 287, Florida Statutes.

(i) The commission may obtain information and assistance from any officer or agency of the state or any subdivision thereof. All such officers and agencies shall give the commission all relevant information and reasonable assistance on any matter of research within their knowledge and control.

Section 99. (1) The Legislature recognizes the importance of providing early prenatal care as a primary means to ensure healthy births. The Legislature also recognizes that one of the most effective weapons in the fight against infant mortality is early, high quality, and comprehensive prenatal care. Despite this convincing evidence that prenatal care is effective in improving pregnancy outcomes, access to prenatal care for all pregnant women has not been achieved in this state. Therefore, it is the intent of the Legislature to assure that the existing economic, social, and geographic barriers to health care are minimized, and that an adequate number of health care providers remain available to assist pregnant women and their infants.

(2) Therefore, it is the overall intent of the Legislature to promote and protect the health and well being of all pregnant women and their children through the provision and accessibility of health care programs to fully meet the health requirements of this population.

(3) The Legislature recognizes the importance of community-based coalitions that combine the resources and talents of its citizenry with involvement of its local business communities. The Legislature also believes that information derived through community involvement is a vital contribution to the success of any state initiative, and is desirous to use this information where available and accessible. Therefore, it is the intent of the Legislature to provide assistance in the establishment of such coalitions in order to ensure that the voice of Florida's communities be heard through the creation of prenatal and infant health care coalitions.

Section 100. Effective March 1, 1992, section 383.14, Florida Statutes, 1990 Supplement, is amended to read:

383.14 Screening ~~of infants~~ for metabolic *disorders,* ~~and~~ other hereditary and congenital disorders, *and environmental risk factors.*—

(1) SCREENING REQUIREMENTS.—To help ensure access to the maternal and child health care system, ~~It shall be the duty of~~ the Department of Health and Rehabilitative Services *shall* ~~to~~ promote the screening of all infants born in Florida for phenylketonuria and other metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. *The department shall also promote the identification and screening of all infants born in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and intervention efforts shall begin prior to and immediately following the birth of the child by the attending health care provider. Such efforts shall be conducted in hospitals, perinatal centers, county public health units, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.*

(a) Prenatal screening.—The department shall develop a multilevel screening process that includes a risk-assessment instrument to identify women at risk for a preterm birth or other high-risk condition. The primary health care provider shall complete the risk-assessment instrument and report the results to the Office of Vital Statistics so that the woman may immediately be notified and referred to appropriate health, education, and social services.

(b) Postnatal screening.—A risk-factor analysis using the department's designated risk-assessment instrument shall also be conducted as part of the medical screening process upon the birth of a child and submitted to the department's Office of Vital Statistics for recording and other purposes provided for in this chapter. The department's screening process for risk assessment shall include a scoring mechanism and procedures that establish thresholds for notification, further assessment, referral, and eligibility for services by professionals or paraprofessionals consistent with the level of risk. Procedures for developing and using the screening instrument, notification, referral, and care coordi-

nation services, reporting requirements, management information, and maintenance of a computer-driven registry in the Office of Vital Statistics which ensures privacy safeguards must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter. Procedures established for reporting information and maintaining a confidential registry must include a mechanism for a centralized information depository at the state and county levels. The department shall coordinate with existing risk-assessment systems and information registries. The department must ensure, to the maximum extent possible, that the screening information registry is integrated with the department's automated data systems, including the Florida On-line Recipient Integrated Data Access (FLORIDA) system. Tests *and screenings must* ~~shall~~ be performed at such times and in such manner as *is* ~~may be~~ prescribed by the department after consultation with the Genetics and Infant Screening Advisory Council *and the State Coordinating Council for Early Childhood Services.*

(2)~~(1)~~ RULES.—After consultation with the Genetics and Infant Screening Advisory Council, the department shall *adopt* ~~promulgate~~ and enforce rules requiring that every infant born in *this state* ~~Florida~~ shall, prior to becoming 2 weeks of age, be subjected to a test for phenylketonuria and, at the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary from time to time. *After consultation with the State Coordinating Council for Early Childhood Services, the department shall also adopt and enforce rules requiring every infant born in this state to be screened for environmental risk factors that place children and their families at risk for increased morbidity, mortality, and other negative outcomes.* The department is empowered to promulgate such additional rules as are found necessary for the administration of this section, including rules relating to the methods used and time or times for testing as accepted medical practice indicates, and rules requiring mandatory reporting of the results of tests *and screenings* for these conditions to the department.

(3)~~(2)~~ DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES; POWERS AND DUTIES.—The department shall administer and provide certain services to implement the provisions of this section and shall:

(a) Assure the availability and quality of the necessary laboratory tests and materials.

(b) Furnish all physicians, *county* public health units, *perinatal centers, birthing centers,* and hospitals forms on which *environmental screening and* the results of tests for phenylketonuria and such other disorders for which testing may be required from time to time shall be reported to the department.

(c) Promote education of the public about the prevention and management of metabolic, hereditary, and congenital disorders *and dangers associated with environmental risk factors.*

(d) Maintain a confidential registry of cases, including information of importance for the purpose of followup services to prevent mental retardation, to correct or ameliorate physical handicaps, and for epidemiologic studies, if indicated. Such registry shall be exempt from the provisions of s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

(e) Supply the necessary dietary treatment products where practicable for diagnosed cases *of phenylketonuria and other metabolic diseases* for as long as medically indicated when the products are not otherwise available. *Provide nutrition education and supplemental foods to those families eligible for the Special Supplemental Food Program for Women, Infants, and Children as provided in s. 383.011.*

(f) Promote the availability of genetic studies and counseling in order that the parents, siblings, and affected infants may benefit from available knowledge of the condition.

All provisions of this subsection shall be coordinated with the provisions and plans established under this chapter, chapter 411, and Pub. L. No. 99-457.

(4)~~(3)~~ OBJECTIONS OF PARENT OR GUARDIAN.—The provisions of this section shall not apply when the parent or guardian of the child objects thereto. A written statement of such objection shall be presented to the physician or other person whose duty it is to administer and report ~~such~~ tests *and screenings* under ~~the provisions of~~ this section.

(5)~~(4)~~ ADVISORY COUNCIL.—There is established a Genetics and Infant Screening Advisory Council made up of 12 members appointed by the Secretary of Health and Rehabilitative Services. The council shall be composed of two consumer members, three practicing pediatricians, at least one of whom must be a pediatric hematologist, one representative from each of the four medical schools in the state, the Deputy Secretary for Health or his designee, one representative from the Children's Medical Services Program Office, and one representative from the Developmental Services Program Office. All appointments shall be for a term of 4 years. The chairperson of the council shall be elected from the membership of the council and shall serve for a period of 2 years. The council shall meet at least semiannually or upon the call of the chairperson. The council may establish ad hoc or temporary technical advisory groups to assist the council with specific topics which come before the council. Council members shall serve without pay. Pursuant to the provisions of s. 112.061, the council members are entitled to be reimbursed for per diem and travel expenses. It is the purpose of the council to advise the department about:

(a) Conditions for which testing should be included under the screening program and the genetics program;

(b) Procedures for collection and transmission of specimens and recording of results; and

(c) Methods whereby screening programs and genetics services for children now provided or proposed to be offered in the state may be more effectively evaluated, coordinated, and consolidated.

Section 101. Effective upon this act becoming a law, subsection (1) of section 383.011, Florida Statutes, is amended to read:

383.011 Administration of maternal and child health programs.—

(1) The Department of Health and Rehabilitative Services is designated as the state agency for:

(a) Administering or providing for maternal and child health services to provide periodic prenatal care for patients who are at low or medium risk of complications during pregnancy and to provide referrals to higher level medical facilities for those patients who develop medical conditions for which treatment is beyond the scope and capabilities of the county public health units.

(b) Administering or providing for periodic medical examinations, nursing appraisals, and nutrition counseling on infant and child patients to assess developmental progress and general health conditions; administering or providing for treatment for health complications when such treatment is within the scope and capabilities of the county public health units or Children's Medical Services.

(c) Administering and providing for the expansion of the maternal and child health services to include pediatric primary care programs subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.

(d) Administering and providing for prenatal and infant health care delivery services through county public health units or subcontractors for the provision of the following enhanced services for medically and socially high-risk clients subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216:

1. Case finding or outreach.

2. Assessment of health, social, environmental, and behavioral risk factors.

3. Case management utilizing a service delivery plan.

4. Home visiting to support the delivery of and participation in prenatal and infant primary health care services.

5. Childbirth and parenting education.

(e) The department shall establish in each county public health unit a Healthy Start Care Coordination Program in which a care coordinator is responsible for receiving screening reports and risk-assessment reports from the Office of Vital Statistics; conducting assessments as part of a multidisciplinary team, where appropriate; providing technical assistance to the district prenatal and infant care coalitions; directing family outreach efforts; and coordinating the provision of services

within and outside the department using the plan developed by the coalition. The care coordination process must include, at a minimum, family outreach workers and health paraprofessionals who will assist in providing the following enhanced services to pregnant women, infants, and their families that are determined to be at potential risk by the department's screening instrument: case finding or outreach; assessment of health, social, environmental, and behavioral risk factors; case management utilizing the family support plan; home visiting to support the delivery of and participation in prenatal and infant primary care services; childbirth and parenting education; counseling; and social services, as appropriate. Family outreach workers may include social work professionals or nurses with public health education and counseling experience. Paraprofessionals may include resource mothers and fathers, trained health aides, and parent educators. The care coordination program shall be developed in a coordinated, nonduplicative manner with the Developmental Evaluation and Intervention Program of Children's Medical Services, using the local assessment findings and plans of the prenatal and infant care coalitions and the programs and services established in chapter 411, Pub. L. No. 99-457, and this chapter.

1. Families determined to be at potential risk based on the thresholds established in the department's screening instrument must be notified by the department of the determination and recommendations for follow-up services. All Medicaid-eligible families shall receive Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services of the Florida Medicaid Program to help ensure continuity of care. All other families identified at potential risk shall be directed to seek additional health care follow-up visits as provided under s. 627 6579. A family identified as a family at potential risk is eligible for enhanced services under the care coordination process within the resources allocated, if it is not already receiving services from the Developmental Evaluation and Intervention Program. The department shall adopt rules regulating the assignment of family outreach workers and paraprofessionals based on the thresholds established in the department's risk-assessment tool.

2. As part of the care coordination process, the department must ensure that subsequent screenings are conducted for those families identified as families at potential risk. Procedures for subsequent screenings of all infants and toddlers must be consistent with the established periodicity schedule and the level of risk. Screening programs must be conducted in accessible locations, such as child care centers, local schools, teenage pregnancy programs, community centers, and county public health units. Care coordination must also include initiatives to provide immunizations in accessible locations. Such initiatives must address ways to ensure that children not currently being served by immunization efforts are reached.

3. The provision of services under this section must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter.

(f)~~(e)~~ Receiving the federal maternal and child health and preventive health services block grant funds.

(g)~~(d)~~ Receiving the federal funds for the "Special Supplemental Food Program for Women, Infants, and Children," or WIC, authorized by the Child Nutrition Act of 1966, as amended, and for administering the statewide WIC program. (The WIC program provides nutrition education and supplemental foods, by means of food instruments called checks that are redeemed by authorized food vendors, to participants certified by the department as pregnant, breast-feeding, or postpartum women; infants; or children.)

Section 102. Effective upon this act becoming a law, subsection (7) is added to section 383.013, Florida Statutes, to read:

383.013 Prenatal care.—The Department of Health and Rehabilitative Services shall:

(7) Provide regional perinatal intensive care satellite clinics to deliver level III obstetric outpatient services to women diagnosed as being high risk, which includes an interdisciplinary team to deliver specialized high-risk obstetric care. The provision of satellite clinics is subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.

Section 103. Effective upon this act becoming a law, subsections (2) and (4) of section 383.215, Florida Statutes, are amended to read:

383.215 Developmental intervention and parent support and training programs.—

(2) It is the intent of the Legislature to establish developmental intervention and parent support and training programs at all Level III regional perinatal intensive care centers and *at hospitals with level II neonatal* ~~stepdown perinatal~~ intensive care *units* ~~centers~~, in order that families with high-risk or handicapped infants may gain the services and skills they need to support their infant. *It is also the intent of the Legislature to establish Developmental Evaluation and Intervention (DEI) programs at hospitals with level II neonatal intensive care units. The provision of developmental evaluation and intervention care units is subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.*

(4) The developmental intervention and family support and training programs shall be established in conjunction with the Level III regional perinatal intensive care centers. *Developmental Evaluation and Intervention (DEI)* ~~Additional~~ programs *shall also* ~~may~~ be established at *hospitals with level II neonatal* ~~stepdown perinatal~~ intensive care *units* ~~centers~~ based on geographic location and population. *The provision of developmental evaluation and intervention care units is subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.* Each program shall have a program director and the necessary staff. The program director shall establish and coordinate the developmental intervention and family support and training program. The program shall include:

(a) In-hospital intervention services, parent support and training, and individual and family service planning.

(b) Interdisciplinary team meetings on a regular basis to develop and update the individual and family service plan.

(c) Discharge planning by the interdisciplinary team.

(d) Education and training for neonatal intensive care unit staff, volunteers, and others, as needed, in order to expand the services provided to high-risk or handicapped infants and their families.

(e) Followup intervention services after hospital discharge, to aid the family and high-risk or handicapped infant's transition into the community. These services shall include home intervention services and non-home-based intervention services, both contractual and voluntary.

(f) Coordination of services with community providers.

(g) Educational materials about infant care, infant growth and development, community resources, medical conditions and treatments, and family advocacy.

Section 104. Effective upon this act becoming a law, section 383.216, Florida Statutes, is created to read:

383.216 Community-based prenatal and infant health care.—

(1) The Department of Health and Rehabilitative Services shall cooperate with localities which wish to establish prenatal and infant health care coalitions, and shall acknowledge and incorporate, if appropriate, existing community children's services organizations, pursuant to this section within the resources allocated. The purpose of this program is to establish a partnership among the private sector, the public sector, state government, local government, community alliances, and maternal and child health care providers, for the provision of coordinated community-based prenatal and infant health care. The prenatal and infant health care coalitions must work in a coordinated, nonduplicative manner with local health planning councils established pursuant to s. 381.703.

(2) Each prenatal and infant health care coalition shall develop, in coordination with the Department of Health and Rehabilitative Services, a plan which shall include at a minimum provision to:

(a) Perform community assessments, using the Planned Approach to Community Health (PATCH) process, to identify the local need for comprehensive preventive and primary prenatal and infant health care. These assessments shall be used to:

1. Determine the priority target groups for receipt of care.

2. Determine outcome performance objectives jointly with the department.

3. Identify potential local providers of services.

4. Determine the type of services required to serve the identified priority target groups.

5. Identify the unmet need for services for the identified priority target groups.

(b) Design a prenatal and infant health care services delivery plan which is consistent with local community objectives and this section.

(c) Solicit and select local service providers based on reliability and availability, and define the role of each in the services delivery plan.

(d) Determine the allocation of available federal, state, and local resources to prenatal and infant health care providers.

(e) Review, monitor, and advise the department concerning the performance of the services delivery system, and make any necessary annual adjustments in the design of the delivery system, the provider composition, the targeting of services, and other factors necessary for achieving projected outcomes.

(f) Build broad-based community support.

(3) Supervision of the prenatal and infant health care coalitions is the responsibility of the department. The department shall:

(a) Assist in the formation and development of the coalitions.

(b) Define the core services package so that it is consistent with the prenatal and infant health care services delivery plan.

(c) Provide data and technical assistance.

(d) Assure implementation of a quality management system within the provider coalition.

(e) Define statewide, uniform eligibility and fee schedules.

(f) Evaluate provider performance based on outcome measures established by the prenatal and infant health care coalition and the department.

(4) In those communities which do not elect to establish a prenatal and infant health care coalition, the Department of Health and Rehabilitative Services is responsible for all of the functions delegated to the coalitions in this section.

(5) The membership of each prenatal and infant health care coalition shall represent health care providers, the recipient community, and the community at large; shall represent the racial, ethnic, and gender composition of the community; and shall include at least the following:

(a) Consumers of family planning, primary care, or prenatal care services, at least two of whom are low-income or Medicaid eligible.

(b) Health care providers, including:

1. County public health units.

2. Migrant and community health centers.

3. Hospitals.

4. Local medical societies.

5. Local health planning organizations.

(c) Local health advocacy interest groups and community organizations.

(d) County and municipal governments.

(e) Social service organizations.

(f) Local education communities.

(6) Prenatal and infant health care coalitions may be established for single counties or for services delivery catchment areas. A prenatal and infant health care coalition shall be initiated at the local level on a voluntary basis. Once a coalition has been organized locally and includes the membership specified in subsection (5), the coalition must submit a list of its members to the Secretary of Health and Rehabilitative Services to carry out the responsibilities outlined in this section.

(7) Effective January 1, 1992, the Department of Health and Rehabilitative Services shall provide up to $150,000 to each prenatal and infant health care coalition that petitions for recognition, meets the membership criteria, demonstrates the commitment of all the designated members to participate in the coalition, and provides a local cash or in-kind contribution match of 25 percent of the costs of the coalition. An in-kind contribution match may be in the form of staff time, office facilities, or supplies or other materials necessary for the functioning of the coalition.

(8) Local prenatal and infant health care coalitions may hire staff or contract for independent staffing and support to enable them to carry out the objectives of this section. Staff shall have knowledge and expertise in community health and related resources and planning, grant writing, public information and communication techniques, organizational development, and data compilation and analysis.

(9) Local prenatal and infant health care coalitions shall incorporate as not-for-profit corporations for the purpose of seeking and receiving grants from federal, state, and local government and other contributors.

(10) The Department of Health and Rehabilitative Services shall adopt rules as necessary to implement this section, including rules defining acceptable "in-kind" contributions.

Section 105. Effective upon this act becoming a law, section 383.2161, Florida Statutes, is created to read:

383.2161 Maternal and child health report.—Beginning in 1993, the Department of Health and Rehabilitative Services annually shall compile and analyze the risk information collected by the Office of Vital Statistics and the district prenatal and infant care coalitions and shall prepare and submit to the Legislature by January 2 a report that includes, but is not limited to:

(1) The number of families identified as families at potential risk;

(2) The number of families that receive family outreach services;

(3) The increase in demand for services; and

(4) The unmet need for services for identified target groups.

Section 106. (1) The Department of Health and Rehabilitative Services shall develop, for submission to the Legislature by December 1, 1991, a plan for decategorizing the resources provided to two districts into a single child and maternal health budget. The plan must establish procedures to allow for allocating resources on the basis of child and maternal welfare concerns, as opposed to specific program categories, using the assessment findings of the district prenatal and infant care coalitions established in section 383.135, Florida Statutes.

(2) The department shall develop, as a part of this plan, an alternative reimbursement methodology for providers that provide performance-based payment and payment that rewards providers who develop social services and educational linkages and support services. The methodology shall be designed to enhance services by increasing resource flexibility within current budgetary levels. The department shall develop this plan in consultation with the appropriate substantive committees in the Legislature and state advisory councils.

Section 107. Effective upon this act becoming a law, paragraph (k) is added to subsection (1) of section 427.012, Florida Statutes, to read:

427.012 Transportation Disadvantaged Commission.—There is created a Transportation Disadvantaged Commission in the Department of Transportation.

(1) The commission shall consist of the following members:

(k) One member of the Early Childhood Council. Such person shall be appointed by the Governor to represent maternal and child health care providers and shall be appointed to serve a term of 4 years.

Section 108. Subsections (2) and (3) of section 395.0335, Florida Statutes, 1990 Supplement, are amended to read:

395.0335 Selection of state-sponsored trauma centers.—

(2)(a) By September 1, 1990, the department shall notify each acute care general hospital in the state that the department is accepting letters of intent from hospitals which are interested in becoming state-sponsored trauma centers. In order to be considered by the department, letters of intent must be postmarked no later than midnight October 1, 1990.

(b) By October 15, 1990, the department shall send to all hospitals which submitted a letter of intent an application package which will provide the hospitals with instructions for submitting information to the department for selection as a state-sponsored trauma center. The standards for verification of trauma centers and pediatric trauma referral centers provided for in s. 395.031(5), as adopted by rule of the department, shall serve as the basis for these instructions.

(c) Those hospitals which have been verified trauma centers since December 1, 1989, shall have their current verification period extended to May 1, 1991.

(d) In order to be considered by the department, applications from those hospitals seeking selection as state-sponsored trauma centers, including those current verified trauma centers which seek to be state-sponsored trauma centers, must be received by the department no later than the close of business on April 1, 1991. The department shall conduct a preliminary review of each application for the purpose of determining that the hospital's application is complete and that the hospital has the critical elements to become a state-sponsored trauma center. This critical review will be based on trauma center verification standards and shall include, but not be limited to, a review of whether the hospital has:

1. Equipment and physical facilities necessary to provide trauma services.

2. Personnel in sufficient numbers and with proper qualifications to provide trauma services.

3. An effective quality assurance process.

(e)1. Notwithstanding other provisions in this section, the department may grant up to an additional 18 months to a hospital applicant that is unable to meet all requirements as provided in paragraph (d) at the time of application if the number of applicants in the service area in which the applicant is located is equal to or less than the service area allocation, as provided by rule of the department. An applicant that is granted additional time pursuant to this paragraph shall submit a plan for departmental approval, which includes timeframes and activities that the applicant proposes to complete in order to meet application requirements. Any applicant that demonstrates an ongoing effort to complete the activities within the timeframes outlined in the plan shall be included in the number of state-sponsored trauma centers at such time that the department has conducted a preliminary review of the application and has determined that the application is complete and that the hospital has the critical elements to become a state-sponsored trauma center.

2. Timeframes provided in this section shall be stayed until the department determines that the application is complete and that the hospital has the critical elements to become a state-sponsored trauma center.

(3) After April 30, 1991, and until state-sponsored trauma centers are selected, any hospital which submitted an application found acceptable by the department based on preliminary review, *including any trauma center verified as of December 1, 1989,* shall be eligible to operate as a provisional state-sponsored trauma center. A hospital with an application found to be unacceptable by the department shall be given opportunity to provide additional information or clarification, but shall not be included within the timeframes outlined in subsections (1)-(8).

Section 109. Section 395.034, Florida Statutes, 1990 Supplement, is amended to read:

395.034 Reimbursement of state-sponsored trauma centers.—

(1) LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that many hospitals which provide services to trauma victims are not adequately compensated for such treatment. The Legislature also recognizes that the current verified trauma centers are providing such services without adequate reimbursement. Therefore, it is the intent of the Legislature to provide financial support to the current verified trauma centers and to establish a system of state-sponsored trauma centers as soon as feasibly possible. It is also the intent of the Legislature that this system of state-sponsored trauma centers be assisted financially based on the volume and acuity of uncompensated trauma care provided.

(2) DEFINITIONS.—As used in this section:

(a) "Board" means the Health Care Cost Containment Board.

(b) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the department for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal ~~nonfarm~~ poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds 4 times the federal ~~nonfarm~~ poverty level for a family of four be considered charity.

(c) "Department" means the Department of Health and Rehabilitative Services.

(d) "Hospital" means a health care institution as defined in s. 395.002(6).

(e) "State-sponsored trauma center" means a verified trauma center selected by the department to receive state funding pursuant to s. 395.0335, for the purpose of furnishing trauma care services.

(3) Provisional *state-sponsored trauma centers* and ~~permanent~~ state-sponsored trauma centers are eligible for state funding under this section.

(4) To receive state funding, a state-sponsored trauma center shall submit *a claim electronically via the trauma claims processing system designed, developed, implemented, and operated by the department's Medicaid program* ~~a completed standard hospital claim form~~ to the department's Medicaid program upon discharge of a trauma patient. *When a hospital stay spans two state fiscal years, a separate hospital claim shall be submitted for the hospital days incurred in each fiscal year.*

(5)(a) State-sponsored trauma centers shall determine each trauma patient's eligibility for state funding prior to the submission of a claim.

(b) A trauma patient treated must meet the definition of charity care, have been designated as having an ISS score of 9 or greater, and have *received from* ~~been treated at~~ a state-sponsored trauma center *services that are medically necessary,* in order for the state-sponsored trauma center to receive state funding for that patient.

(c) Each state-sponsored trauma center shall retain appropriate documentation showing a trauma patient's eligibility for state funding. Documentation recognized by the department as appropriate shall be limited to one of the following:

1. W-2 withholding forms.

2. Payroll stubs.

3. Income tax returns.

4. Forms approving or denying unemployment compensation or workers' compensation.

5. Written verification of wages from employer.

6. Written verification from public welfare agencies or any other governmental agency which can attest to the patient's income status for the past 12 months.

7. A witnessed statement signed by the patient or responsible party, as provided for in Pub. L. No. 79-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within 48 hours of the patient's admission to the hospital as required by the Hill-Burton Act. The statement shall include acknowledgment that, in accordance with s. 817.50, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor of the second degree.

(d) The department shall conduct an audit or shall contract with an independent party to conduct an audit of each state-sponsored trauma center's claims to ensure that state funding was only provided for eligible trauma patients *and medically necessary services.*

(e) The *department's Medicaid program* ~~fiscal agent~~ shall check each claim to confirm that the patient is not covered under the Medicaid program and shall pay the claim out of the Trauma Services *Account within the Emergency Medical Services* Trust Fund. *Trauma patients who are eligible for the Medicaid program are ineligible for the state-sponsored trauma center program except for Medicaid noncovered services. If a claim is denied by the trauma claims processing system as a result of Medicaid eligibility for Medicaid-covered services, the hospital shall*

submit a claim to the Medicaid fiscal agent for payment. ~~If the patient is eligible for Medicaid the claim shall be submitted for processing as a Medicaid claim.~~

(6) Effective *January 1, 1992* ~~October 1, 1990~~, state funding *to provisional and state-sponsored trauma centers* shall be at a per diem rate equal to *$860* ~~$860.00~~. This rate shall remain in effect until *July 1, 1993* ~~July 1, 1991~~, at which time payment ~~to provisional and state-approved state-sponsored trauma centers~~ shall be based on a trauma cost-based reimbursement methodology developed by the Department of Health and Rehabilitative Services. The department shall consult with representatives from the hospital industry including the Florida Hospital Association, the Association of Voluntary Hospitals of Florida, and the Florida League of Hospitals in the development of the reimbursement methodology.

(7)(a) To ensure a fair distribution of funds appropriated for state-sponsored trauma centers and to ensure that no state-sponsored trauma center gains an unfair advantage due solely to its ability to bill more quickly than another state-sponsored trauma center, the total amount of state funds *appropriated in the General Appropriations Act for* ~~appropriated under~~ this section shall be divided into 19 trauma fund accounts with an account for each service area established in s. 395.033(3). The amount of funds distributed to a service area shall be based on the following formula:

$$SAAA = \frac{SATD}{TTD} \times TA$$

where:

SAAA = service area appropriation amount.

SATD = *uncompensated* service area trauma days with ISS score of 9 or greater.

TTD = *uncompensated* total trauma days with ISS score of 9 or greater for all 19 service areas.

TA = total dollars appropriated for state-sponsored trauma centers.

(b) The data base to be used for this calculation shall be the detailed patient discharge data *for the most recently completed calendar year that is in the possession* of the Health Care Cost Containment Board. *Out-of-state days that are included in the data base shall be allocated to the service area where the treating hospital is located.*

(c) Fifty percent of the funds allocated to those service areas which had one or more trauma centers as of December 1, 1989, shall be distributed to those verified trauma centers proportionately based on volume and acuity of uncompensated trauma care provided during *the most recently completed calendar year for which the Health Care Cost Containment Board possesses data* ~~calendar year 1988~~ in a lump sum payment on *January 1, 1992* ~~October 1, 1990~~. These trauma centers shall submit claims pursuant to subsection (4) in order to justify this funding. By June 30, *1992* ~~1991~~, any trauma center which fails to submit claims for reimbursement equal to or greater than the amount the trauma center received under the initial allocation shall return any unearned funds to the department for distribution pursuant to paragraph *(e)* ~~(d)~~. Once this 50-percent lump sum is depleted, a trauma center will be reimbursed from the remaining 50 percent of the service area's original allocation.

(d) The department shall pay trauma claims monthly. In any month in which the outstanding claims exceed the unexpended funds allocated to a service area, the department shall pay all of the claims submitted for that service area on a pro rata basis.

(e)~~(d)~~ At the end of the fiscal year, the unexpended funds for each service area shall be placed in one large state trauma account from which all remaining claims are paid without regard to service area on a pro rata basis until such funds are depleted.

(f) For *any* ~~the~~ state fiscal year ~~1990-1991~~, reimbursement for any patient residing outside the trauma service area of the state-sponsored trauma center where the patient is treated shall be paid out of the funds allocated for the trauma service area where the patient resides. *Out-of-state days shall be paid from the service area where the treating hospital is located.*

(8) In order to receive payments under this section, a hospital shall be a state-sponsored trauma center and shall:

(a) Agree to conform to all departmental requirements as provided by rule to assure high quality trauma services.

(b) Agree to provide information concerning the provision of trauma services to the department, in a form and manner prescribed by rule of the department.

(c) Agree to accept all trauma patients, regardless of ability to pay, on a functional space-available basis.

~~(d) Agree to develop arrangements with other Level I and II trauma centers and other state-sponsored trauma centers and community hospitals for the appropriate receipt and transfer of patients in need of trauma services.~~

(9) A state-sponsored trauma center which fails to comply with any of the conditions listed in subsection (8) or the applicable rules of the department shall not receive payments under this section for the period in which it was not in compliance.

~~(10) Beginning October 1, 1990, verified trauma centers shall be eligible for reimbursement for trauma services according to the formula specified in subsection (7) within funds specifically appropriated for that purpose for the period October 1, 1990, through April 30, 1991.~~

(10)~~(11)~~ Beginning *January* ~~May~~ 1, *1992* ~~1991~~, provisional state-sponsored trauma centers shall be eligible for reimbursement for trauma services according to the formula specified in subsection (7) with funds specifically appropriated for that purpose for ~~the periods of May and June of state fiscal year 1990-1991 and July through March of~~ state fiscal year 1991-1992.

(11)~~(12)~~ In state fiscal year 1992-1993 and subsequent fiscal years, state-sponsored trauma centers shall be eligible for reimbursement for trauma services according to the formula specified in subsection (7) with funds specifically appropriated for that purpose.

(12) Funds distributed to a hospital pursuant to this section are not net revenues of the hospital for purposes of determining whether an excess has occurred under s. 407.51. Hospital charges in excess of per diem payments under this program constitute charity care.

Section 110. Section 395.0345, Florida Statutes, 1990 Supplement, is amended to read:

395.0345 Trauma Services Trust Fund.—

(1) There is hereby created the Trauma Services Trust Fund *in the State Treasury*, which shall be used exclusively for *the development and support of a system of state-sponsored trauma centers. Trust fund revenue shall be used for* the purpose of funding trauma patient care in a ~~verified trauma center, a~~ provisional state-sponsored trauma center, or a ~~permanent~~ state-sponsored trauma center as provided for in this act; for funding the associated trauma claims processing costs, including the costs for the *design,* development, *implementation, and operation* of a payment system, ~~not to exceed $400,000~~; and for administration of this act, ~~not to exceed $250,000~~. The department is authorized to establish *9* ~~5~~ positions for *administrative and claims processing responsibilities associated with* ~~administration of~~ this act.

(2) Any funds appropriated in the General Appropriations Act for the implementation of this act, *and* ~~or~~ any other funds *that* ~~which~~ become available for the implementation of this act, may be deposited in the Trauma Services Trust Fund.

Section 111. Notwithstanding the provisions of section 395.0345, Florida Statutes, 1990 Supplement, $2.5 million is appropriated for fiscal year 1991-1992 from the Trauma Services Trust Fund to the Department of Health and Rehabilitative Services to fund the state share of the Medicaid emergency transportation services enhancements contained in section 10 of chapter 90-284, Laws of Florida.

Section 112. Effective January 1, 1992, and for the remainder of the 1991-1992 fiscal year, all funds in the Trauma Services Trust Fund are appropriated to the Department of Health and Rehabilitative Services to carry out the requirements of sections 395.0335 and 395.034, Florida Statutes. Of this amount, $295,353 and 5 positions and related expenses are allocated to the office of the Deputy Secretary for Health to administer a system of state-sponsored trauma centers; $400,000 is allocated to the office of the Deputy Secretary for Health to provide the review team of out-of-state experts pursuant to section 395.0335(5), Florida Statutes; $400,000 and 4 positions and related expenses are allocated to the Deputy

Secretary for Programs, Medicaid Program Planning to design, develop, implement, and operate the Trauma Claims Processing System within the department's Medicaid program; and the balance is allocated to the Medicaid services budget entity as a special grant-in-aid category to reimburse provisional state-sponsored trauma centers and state-sponsored trauma centers for the provision of trauma patient services.

Section 113. Paragraph (t) of subsection (1) and subsection (6) of section 458.331, Florida Statutes, 1990 Supplement, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of *$25,000* ~~$10,000~~ each to the claimant in a judgment ~~or settlement~~ and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 455.247, or upon the receipt from a claimant of a presuit notice against a physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that a physician has had three or more *judgments* ~~claims~~ with indemnities exceeding $25,000 each within the previous 5-year period, the department shall investigate the occurrences upon which the *judgments* ~~claims~~ were based and determine if action by the department against the physician is warranted.

Section 114. Paragraph (y) of subsection (1) and subsection (6) of section 459.015, Florida Statutes, 1990 Supplement, are amended to read:

459.015 Grounds for disciplinary action by the board.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(y) Gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of *$25,000* ~~$10,000~~ each to the claimant in a judgment ~~or settlement~~ and which incidents involved negligent conduct by the osteopathic physician. As used in this paragraph, "gross malpractice" or "the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that an osteopathic physician be incompetent to practice osteopathic medicine in order to be disciplined pursuant to this paragraph. A recommended order by a hearing officer or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board shall so specify.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against an osteopathic physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 455.247, or upon the receipt from a claimant of a presuit notice against an osteopathic physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that an osteopathic physician has had three or more *judgments* ~~claims~~ with indemnities exceeding $25,000 each within the previous 5-year period, the department shall investigate the occurrences upon which the *judgments* ~~claims~~ were based and determine if action by the department against the osteopathic physician is warranted.

Section 115. Paragraph (t) of subsection (1) and paragraph (a) of subsection (5) of section 461.013, Florida Statutes, 1990 Supplement, are amended to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(t) Gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatrist as being acceptable under similar conditions and circumstances. The board shall give great weight to the standards for malpractice in s. 766.102 in interpreting this section. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of *$25,000* ~~$10,000~~ each to the claimant in a judgment ~~or settlement~~ and which incidents involved negligent conduct by the podiatrists. As used in this paragraph, "gross malpractice" or "the failure to practice podiatry with the level of care, skill, and treatment which is recognized by a reasonably prudent similar podiatrist as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act.

(5)(a) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a podiatrist pursuant to s. 627.912, or upon the receipt from a claimant of a presuit notice against a podiatrist pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that a podiatrist has had three or more *judgments* ~~claims~~ with indemnities exceeding $25,000 each within the previous 5-year period, the department shall investigate the occurrences upon which the *judgments* ~~claims~~ were based and determine if action by the department against the podiatrist is warranted.

Section 116. Paragraph (y) of subsection (1) and subsection (6) of section 466.028, Florida Statutes, 1990 Supplement, are amended to read:

466.028 Grounds for disciplinary action; action by the board.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(y) Being guilty of incompetence or negligence by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance, including, but not limited to, the undertaking of diagnosis and treatment for which the dentist is not qualified by training or experience or being guilty of dental malpractice. For purposes of this paragraph, it shall be legally presumed that a dentist is not guilty of incompetence or negligence by declining to treat an individual if, in the dentist's professional judgment, the dentist or a member of his clinical staff is not qualified by training and experience, or the dentist's treatment facility is not clinically satisfactory or properly equipped to treat the unique characteristics and health status of the dental patient, provided the dentist refers the patient to a qualified dentist or facility for appropriate treatment. As used in this paragraph, "dental malpractice" includes, but is not limited to, three or more claims within the previous 5-year period which resulted in indemnity being paid, or any single indemnity paid in excess of *$25,000* ~~$5,000~~ in a judgment ~~or settlement~~, as a result of negligent conduct on the part of the dentist.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a dentist pursuant to s. 627.912 or upon

the receipt from a claimant of a presuit notice against a dentist pursuant to s. 766.106 the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that a dentist has had any indemnity paid in excess of $25,000 in a judgment ~~or settlement~~ or has had three or more *judgments* ~~claims~~ for dental malpractice within the previous 5-year period which resulted in indemnity being paid, the department shall investigate the occurrence upon which the *judgments* ~~claims~~ were based and determine if action by the department against the dentist is warranted.

Section 117. For the purpose of incorporating the amendments to sections 458.331, 459.015, 461.013, and 466.028, Florida Statutes, in references thereto, subsection (2) of section 455.241, Florida Statutes, 1990 Supplement, is reenacted to read:

455.241 Patient records; report or copies of records to be furnished.—

(2) Except as otherwise provided in s. 440.13(2)(c), such records shall not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or his legal representative or other health care providers involved in the care or treatment of the patient, except upon written authorization of the patient. However, such records may be furnished without written authorization to any person, firm, or corporation which has procured or furnished such examination or treatment with the patient's consent or when compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff. Such records may be furnished in any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or his legal representative by the party seeking such records. Except in a medical negligence action when a health care provider is or reasonably expects to be named as a defendant, information disclosed to a health care practitioner by a patient in the course of the care and treatment of such patient is confidential and may be disclosed only to other health care providers involved in the care or treatment of the patient, or if permitted by written authorization from the patient or compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given. The Department of Professional Regulation may obtain patient records pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a practitioner has excessively or inappropriately prescribed any controlled substance specified in chapter 893 in violation of s. 458.331(1)(q), s. 459.015(1)(u), s. 461.013(1)(p), s. 462.14(1)(q), s. 466.028(1)(q), or s. 474.214(1)(x) or (y) or that a practitioner has practiced his profession below that level of care, skill, and treatment required as defined by s. 458.331(1)(t), s. 459.015(1)(y), s. 460.413(1)(s), s. 461.013(1)(t), s. 462.14(1)(t), s. 463.016(1)(n), s. 464.018(1)(h), s. 466.028(1)(y), or s. 474.214(1)(o); provided, however, the patient record obtained by the department pursuant to this subsection shall be used solely for the purpose of the department and board in disciplinary proceedings. The record shall otherwise be sealed and shall not be available to the public pursuant to the provisions of s. 119.07 or any other statute providing access to public records. Nothing in this section shall be construed to limit the assertion of the psychotherapist-patient privilege under s. 90.503 in regard to records of treatment for mental or nervous disorders by a medical practitioner licensed pursuant to chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency. However, the practitioner shall release records of treatment for medical conditions even if the practitioner has also treated the patient for mental or nervous disorders. If the department has found reasonable cause under this section and the psychotherapist-patient privilege is asserted, the department may petition the circuit court for an in camera review of the records by expert medical practitioners appointed by the court to determine if the records or any part thereof are protected under the psychotherapist-patient privilege.

Section 118. For the purpose of incorporating the amendments to sections 458.331 and 459.015, Florida Statutes, in reference thereto, subsection (3) of section 455.245, Florida Statutes, is reenacted to read:

455.245 Health care practitioners; immediate suspension of license for certain convictions.—

(3) If the board has previously found any physician or osteopathic physician in violation of the provisions of s. 458.331(1)(t) or s. 459.015(1)(y), in regard to his treatment of three or more patients, and the probable cause panel of the board finds probable cause of an additional violation of that section, then the secretary shall review the matter to determine if an emergency suspension or restriction order is warranted. Nothing in this section shall be construed so as to limit the secretary's authority to issue an emergency order.

Section 119. For the purpose of incorporating the amendment to section 458.331, Florida Statutes, in references thereto, subsection (5) of section 458.311, Florida Statutes, 1990 Supplement, and subsection (7) of section 458.313, Florida Statutes, 1990 Supplement, are reenacted to read:

458.311 Licensure by examination; requirements; fees.—

(5) The board may not certify to the department for licensure any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter until such investigation is completed. Upon completion of the investigation, the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, then the board may enter an order imposing one or more of the terms set forth in subsection (9).

458.313 Licensure by endorsement; requirements; fees.—

(7) The department shall not issue a license by endorsement to any applicant who is under investigation in any jurisdiction for an act or offense which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, then the board may enter an order imposing one or more of the terms set forth in subsection (8).

Section 120. For the purpose of incorporating the amendment to section 466.028, Florida Statutes, in a reference thereto, section 466 011, Florida Statutes, 1990 Supplement, is reenacted to read:

466.011 Licensure.—The board shall certify for licensure by the department any applicant who satisfies the requirements of s. 466.006 or s. 466.007. The board may refuse to certify an applicant who has violated any of the provisions of s. 466.026 or s. 466.028.

Section 121. Subsection (2) of section 766.106, Florida Statutes, is amended to read:

766.106 Notice before filing action for medical malpractice; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.—

(2) After completion of presuit investigation pursuant to s. 766.203 and prior to filing a claim for medical malpractice, a claimant shall notify each prospective defendant and, if any prospective defendant is a health care provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466, the Department of Professional Regulation by certified mail, return receipt requested, of intent to initiate litigation for medical malpractice. *Notice to such a prospective defendant licensed by the Department of Professional Regulation is sufficient if addressed to the prospective defendant at the address maintained in the records of that department for such prospective defendant.* Notice to the Department of Professional Regulation must include the full name and address of the claimant; the full names and any known addresses of any health care providers licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 who are prospective defendants identified at the time; the date and a summary of the occurrence giving rise to the claim; and a description of the injury to the claimant. The requirement for notice to the Department of Professional Regulation does not impair the claimant's legal rights or ability to seek relief for his claim, and the notice provided to the department is not discoverable or admissible in

any civil or administrative action. The Department of Professional Regulation shall review each incident and determine whether it involved conduct by a licensee which is potentially subject to disciplinary action, in which case the provisions of s. 455.225 apply.

Section 122. For the purpose of incorporating the amendment to section 766.106, Florida Statutes, in references thereto, subsection (9) of section 458.331, Florida Statutes, 1990 Supplement, and subsection (9) of section 459.015, Florida Statutes, 1990 Supplement, are reenacted to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(9) When an investigation of a physician is undertaken, the department shall promptly furnish to the physician or his attorney a copy of the complaint or document which resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of a quarterly report submitted to the department pursuant to s. 395.041(5)(b); a report of an adverse or untoward incident which is provided to the department pursuant to the provisions of s. 395.041(6); a report of peer review disciplinary action submitted to the department pursuant to the provisions of s. 395.0115(4) or s. 458.337, providing that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. 395.0115(7) and 458.337(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the physician of the complaint or document. The physician's written response shall be considered by the probable cause panel.

459.015 Grounds for disciplinary action by the board.—

(9) When an investigation of an osteopathic physician is undertaken, the department shall promptly furnish to the osteopathic physician or his attorney a copy of the complaint or document which resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of a quarterly report submitted to the department pursuant to s. 395.041(5)(b); a report of an adverse or untoward incident which is provided to the department pursuant to the provisions of s. 395.041(6); a report of peer review disciplinary action submitted to the department pursuant to the provisions of s. 395.0115(4) or s. 459.016, provided that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. 395.0115(7) and 459.016(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The osteopathic physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the osteopathic physician of the complaint or document. The osteopathic physician's written response shall be considered by the probable cause panel.

Section 123. Section 766.205, Florida Statutes, is amended to read:

766.205 Presuit discovery of medical negligence claims and defenses.—

(1) Upon the completion of presuit investigation pursuant to s. 766.203, which investigation has resulted in the mailing of a notice of intent to initiate litigation in accordance with s. 766.106, corroborated by medical expert opinion that there exist reasonable grounds for a claim of negligent injury, each party shall provide to the other party reasonable access to information within its possession or control in order to facilitate evaluation of the claim.

(2) Such access shall be provided without formal discovery, pursuant to s. 766.106, and failure to so provide shall be grounds for dismissal of any applicable claim or defense ultimately asserted.

(3) As an exception to s. 455.241, any health care provider noticed pursuant to s. 766.106 (hereinafter referred to as prospective defendant), or the prospective defendant's legal representative or insurer, may request and obtain during the presuit period, or any time thereafter prior to verdict, medical information and records about the patient from any former or current treating health care provider of the patient, and such health care provider may furnish such medical information and records if such health care provider is willing to furnish such information and records voluntarily. However, this subsection does not require a former or current treating health care provider to furnish such medical information or records. Written notice of the furnishing of any such information or records must be provided to the patient or the patient's legal representative by the requestor within 3 business days after any such information or records are obtained. This subsection does not affect other rights or obligations of the parties or any former or current treating health care providers except as provided in this subsection.

(4)~~(3)~~ Failure of any party to comply with this section shall constitute evidence of failure of that party to comply with good-faith discovery requirements and shall waive the requirement of written medical corroboration by the party seeking production.

(5)~~(4)~~ No statement, discussion, written document, report, or other work product generated solely by the presuit investigation process is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, hospitals and other medical facilities, and the officers, directors, trustees, employees, and agents thereof, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit investigation process. Such immunity from civil liability includes immunity for any acts by a medical facility in connection with providing medical records pursuant to s. 766.204(1) regardless of whether the medical facility is or is not a defendant.

Section 124. Paragraph (b) of subsection (4) of section 95.11, Florida Statutes, 1990 Supplement, is amended to read:

95.11 Limitations other than for the recovery of real property.—Actions other than for recovery of real property shall be commenced as follows:

(4) WITHIN TWO YEARS.—

(b) An action for medical malpractice shall be commenced within 2 years from the time the *malpractice* ~~incident giving rise to the action occurred or within 2 years from the time the incident~~ is discovered, or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of the *malpractice occurred* ~~incident or occurrence out of which the cause of action accrued~~. *Discovery of a physical or mental injury, without knowledge that the injury resulted from malpractice, does not constitute knowledge of the malpractice.* An "action for medical malpractice" is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care. The limitation of actions within this subsection shall be limited to the health care provider and persons in privity with the provider of health care. In those actions covered by this paragraph in which it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the *malpractice* ~~injury within the 4-year period~~, the period of limitations is extended forward 2 years from the time that the *malpractice* ~~injury~~ is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed 7 years from the date the *malpractice* ~~incident giving rise to the injury~~ occurred.

Section 125. Each applicant who qualified to take, and before 1989 successfully completed, a course of study approved by the Department of Professional Regulation pursuant to chapter 86-90, Laws of Florida, relating to the subject matter within the jurisdiction of the board provided for in section 466.004, Florida Statutes, may apply for licensure as provided for under section 455.218, Florida Statutes, without having to meet the requirement under section 455.218(1)(f), Florida Statutes, if the applicant meets all other eligibility requirements for licensure under section 455.218, Florida Statutes.

Section 126. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law, except that sections 1 through 85 shall take effect October 1, 1991, and sections 109 through 114 shall take effect July 1, 1991.

Senate Amendment 1 to House Amendment 2—On page 1, line 13 through page 14, line 9, strike all of said lines and insert: A bill to be entitled An act relating to health care; creating s. 395.1015, F.S.; providing for an annual assessment of annual net operating revenues of health care entities; specifying those facilities that are subject to the assessment; providing for deposit of proceeds of the assessment into the Public Medical Assistance Trust Fund; allowing the Health Care Cost Containment Board to impose certain penalties; amending s. 407.50, F.S.; exempting certain hospitals from budget review requirements; creating s. 409.901, F.S.; providing definitions; creating s. 409.902, F.S.; designating the Department of Health and Rehabilitative Services as the single state agency for administering the Florida Medicaid Program; creating s. 409.903, F.S.; specifying those persons who are eligible for payments for services under the Florida Medicaid Program, subject to certain limitations; creating s. 409.904, F.S.; specifying those persons who are eligible for optional payments for services; creating ss. 409.905, 409.906, F.S.; enumerating federally mandated and optional services to be provided by Medicaid; creating s. 409.907, F.S.; providing requirements for Medicaid provider agreements; providing circumstances under which a provider agreement may be revoked or terminated; creating s. 409.908, F.S.; establishing reimbursement standards for payment for Medicaid services; creating s. 409.909, F.S.; establishing additional reimbursement requirements for nursing home care and prescription drug services under Medicaid; transferring, renumbering, and amending s. 409.2665, F.S., relating to the recovery of Medicaid payments from third-party resources; deleting definitions made obsolete by this act; conforming cross-references to changes made by this act; making technical, clarifying revisions; deleting certain requirements pertaining to the recovery of third-party resources for Medicaid benefits made payable by check; creating s. 409.911, F.S.; authorizing the department to use certain cost-effective methods in purchasing health care; providing standards and requirements for contracts for certain prepaid services; authorizing the department to apply for waivers and establish certain programs in order to reduce costs; prescribing financial requirements for entities contracting on a prepaid per capita or prepaid aggregate fixed sum basis; creating s. 409.912, F.S.; establishing criteria for oversight of goods and services provided under the Florida Medicaid Program; providing for investigations by the Auditor General; exempting certain information pertaining to such investigations from public record laws; providing for future legislative review of this exemption pursuant to the Open Government Sunset Review Act; providing circumstances under which the department may impose administrative sanctions; authorizing the department to recover investigation costs; providing for the department to withhold Medicaid payments during a pending investigation; creating s. 409.913, F.S.; providing penalties for specified actions of Medicaid provider fraud; requiring the Auditor General to conduct a Medicaid Fraud Control program; providing powers and duties; creating s. 409.914, F.S.; requiring county contributions on behalf of certain persons covered by the Florida Medicaid Program, including the establishment of limits thereon and methods for collection; creating s. 409.915, F.S.; requiring the department to use the systems it has developed to manage the Florida Medicaid Program to assist other agencies; creating s. 409.916, F.S.; creating the Public Medical Assistance Trust Fund; creating s. 409.917, F.S.; providing for funds from the Public Medical Assistance Trust Fund to be distributed to hospitals providing a disproportionate share of Medicaid or charity care services; providing formulas to compute the disproportionate share rate; providing for Medicaid payments to hospitals that participate in the Regional Perinatal Intensive Care Center Program; providing payment criteria; creating s. 409.918, F.S.; providing for payments to certain hospitals that make extraordinary contributions to indigent care; providing eligibility criteria for such hospitals; providing methodology for calculating such payments; providing for hospital participation in program funding; creating s. 409.9185, F.S.; providing for a disproportionate share program for teaching hospitals; providing for distribution of funds; providing a formula for maximum payments; transferring, renumbering, and amending s. 409.2666, F.S., relating to the Medicaid Research and Development Trust Fund; deleting obsolete provisions; transferring, renumbering, and amending s. 409.2667, F.S., relating to the receipt and deposit of funds into the Medicaid Research and Development Trust Fund; conforming a cross-reference to changes made by this act; creating s. 409.920, F.S.; requiring the department to adopt rules; amending s. 110.123, F.S., relating to the state group insurance program; s. 154.011, F.S., relating to primary care services; s. 394.4787, F.S., relating to definitions applicable to provision of acute care mental health services; s. 395.01465, F.S., relating to emergency care hospitals; s. 400.126, F.S., relating to receivership of nursing home facilities; s. 400.18, F.S., relating to closing of nursing facilities; s. 400.332, F.S., relating to certain funds received by a nursing home for participation in the geriatric outpatient nurse clinic program; s. 407.51, F.S., relating to hospital budgets; s. 409.2673, F.S., relating to the shared county and state health care program for low-income persons; s. 409.345, F.S., relating to public assistance payments as debt of the recipient; s. 409.701, F.S., the Florida Small Business Health Access Corporation Act; s. 410.036, F.S., relating to eligibility for home care for disabled adults and the elderly; s. 624.424, F.S., relating to statements and records of insurers; s. 627.736, F.S., relating to personal injury protection benefits; s. 631.813, F.S., relating to application of the Florida Health Maintenance Organization Consumer Assistance Plan; s. 641.261, F.S., relating to reporting requirements of health maintenance organizations; s. 641.31, F.S., relating to health maintenance contracts; s. 641.411, F.S., relating to reporting requirements of prepaid health clinics; s. 768.73, F.S., relating to punitive damages; conforming cross-references in said sections to changes by this act or deleting from said sections cross-references made obsolete by this act; amending s. 895.02, F.S.; redefining the term "racketeering activity" for purposes of the Florida RICO (Racketeer Influenced and Corrupt Organization) Act, to include offenses relating to Medicaid fraud; reenacting ss. 655.50(3)(g), 896.101(1)(g), F.S., relating to unlawful financial transactions, to incorporate the amendment to s. 895.02, F.S., in references thereto; saving existing rules until superseded; creating the Task Force on County Contributions to Medicaid; specifying members of the task force; requiring a study of county contributions to the Medicaid Program; requiring a report to be submitted; providing an appropriation; providing that certain nursing home residents may receive Medicare or Medicaid hospice benefits; repealing s. 21, ch. 89-275, Laws of Florida, ss. 400.23(3), 409.266, 409.2662, 409.2663, 409.2664, 409.267, 409.2671, 409.268, F.S., relating to the Medicaid program and payments thereunder; providing an appropriation; amending ss. 641.201, 641.21, F.S.; deleting obsolete language to conform to changes made by the act; providing additional requirements for persons applying for a certificate of authority from the Department of Insurance to operate a health maintenance organization; requiring the Department of Health and Rehabilitative Services to adopt rules governing the operation of certain organizations providing prepaid health care and social services; amending s. 641.22, F.S.; providing additional requirements for obtaining a certificate of authority to operate a health maintenance organization; amending s. 641.221, F.S.; providing requirements for expanding the service area of a health maintenance organization; amending s. 641.23, F.S.; providing additional circumstances under which the department may revoke an organization's certificate of authority; providing a penalty; creating s. 641.275, F.S.; requiring periodic examinations of the quality of health care services provided by health maintenance organizations; exempting certain medical records and examination reports from public records law; providing for future legislative review of these exemptions pursuant to the Open Government Sunset Review Act; providing for subpoenas and enforcement thereof; providing a penalty; providing for the examination of health maintenance organizations that operate under certificates issued by the Department of Health and Rehabilitative Services prior to a specified date; amending s. 641.28, F.S.; deleting obsolete provisions; amending s. 641.29, F.S.; requiring health maintenance organizations to pay an annual assessment; providing for deposit of assessment proceeds into the Health Care Services Trust Fund; creating s. 641.295, F.S.; establishing the Health Care Services Trust Fund; providing for the transfer of certain funds in the Health Maintenance Organization Quality Care Trust Fund into the Health Care Services Trust Fund on a specified date; amending s. 641.30, F.S.; providing circumstances under which certain health maintenance organizations are exempt from specified hospital licensing requirements; transferring, renumbering, and amending s. 641.51, F.S.; prohibiting modification of the professional judgment of certain health care providers under certain circumstances; transferring, renumbering, and amending s. 641.55, F.S.; requiring the Department of Insurance to administer the internal risk management programs of health maintenance organizations; continuing the exemption of certain reports and records from public records law; providing for future review of these exemptions pursuant to the Open Government Sunset Review Act; transferring, renumbering, and amending s. 641.54, F.S., relating to hospital and physician information disclosure; amending s. 641.31, F.S.; requiring health maintenance organizations to provide additional notification regarding subscriber's rights and the organization's grievance process; creating s. 641.31085, F.S.; providing requirements for a subscriber grievance procedure; requiring the department to investigate unresolved grievances; amending s. 641.311, F.S.; authorizing the department to provide for additional members on the grievance review panel; amending s. 641.401, F.S.; providing an additional legislative purpose in regulating prepaid health clinics; amending s. 641.402, F.S.; providing a definition; amending s. 641.405, F.S.; providing additional requirements for persons

applying for a certificate of authority from the Department of Insurance to operate a prepaid health clinic; requiring the Department of Health and Rehabilitative Services to adopt rules governing the operation of certain clinics providing prepaid health care and social services; amending s. 641.406, F.S.; providing additional requirements for obtaining a certificate of authority to operate a prepaid health clinic; amending s. 641.412, F.S.; requiring prepaid health clinics to pay an annual assessment; providing for deposit of assessment proceeds into the Health Care Services Trust Fund; creating s. 641.4185, F.S.; requiring periodic examinations of the quality of health care services provided by prepaid health clinics; exempting certain medical records and examination reports from public records law; providing for future legislative review of these exemptions pursuant to the Open Government Sunset Review Act; providing for subpoenas and enforcement thereof; providing a penalty; providing for the examination of prepaid health clinics that operate under certificates issued by the Department of Health and Rehabilitative Services prior to a specified date; creating s. 641.4187, F.S.; requiring prepaid health clinics to establish internal quality assurance programs; providing program requirements; prohibiting modification of the professional judgment of certain health care providers under certain circumstances; providing prepaid health clinic subscribers the right to a second medical opinion under certain circumstances; amending s. 641.45, F.S.; providing additional circumstances under which the department may revoke a clinic's certificate of authority; amending s. 641.455, F.S.; conforming provisions to changes made by the act; providing an appropriation and authorizing positions; saving existing rules adopted pursuant to part IV of ch. 641, F.S.; providing for a type four transfer of the regulation of health care services from the Department of Health and Rehabilitative Services to the Department of Insurance; requiring the Health Care Cost Containment Board to conduct a study on competition and provider contracts in health maintenance organizations; requiring a report; specifying the contents of the report; requiring the board to appoint a technical advisory panel; specifying panel membership and purposes; requiring state agencies and state officers to provide information and assistance; providing for reimbursement for per diem and travel expenses; repealing ss. 641.47, 641.48, 641.49, 641.495, 641.515, 641.52, 641.56, 641.57, 641.58, F.S., relating to health care services; reviving and readopting parts II and III of ch. 641, F.S., notwithstanding repeals scheduled pursuant to the Regulatory Sunset Act; providing for future review and repeal; amending s. 186.003, F.S.; defining the term "Statewide Health Council"; amending s. 186.022, F.S.; requiring the Executive Office of the Governor to consider findings of the Statewide Health Council's review of agency functional plans; amending s. 186.503, F.S.; defining the terms "local health council" and "Statewide Health Council"; amending s. 186.507, F.S.; requiring memoranda of agreement between regional planning councils and local health councils; amending s. 186.508, F.S.; requiring the Executive Office of the Governor to consider findings of the Statewide Health Council's review of comprehensive regional policy plans; amending s. 186 511, F.S.; requiring involvement of local health councils in the evaluation of the health element of comprehensive regional policy plans; amending s. 187.201, F.S.; substantially rewording the health element of the state comprehensive plan; revising goals and policies; amending s. 381.703, F.S.; providing a schedule for appointing local health council members; revising the functions of the local health councils; changing the composition of the Statewide Health Council; revising the functions of the Statewide Health Council; requiring the Department of Health and Rehabilitative Services to assist the Statewide Health Council in preparing a state health plan and provide orientation to local health council members; authorizing the Department of Health and Rehabilitative Services to withhold funds from or cancel contracts with local health councils under certain circumstances; providing an appropriation; amending s. 401.291, F.S.; revising a training requirement for the use of an automatic external defibrillator; repealing s. 381.025, F.S., relating to long-range health planning; providing legislative intent; establishing the Health Care 2000 Commission; providing for membership, duties, powers, and compensation; requiring the cooperation of state agencies; providing legislative intent relating to indigent health care; amending s. 383.14, F.S.; requiring the screening of infants and their families for specified environmental risk factors; requiring the department to ensure that the screening information registry is integrated with the department's automated data systems; providing for rulemaking; providing for developing a risk-assessment instrument; providing for supplying nutrition education and foods to certain individuals; requiring the coordination of s. 383.14(3), F.S., with certain other legal provisions; amending s. 383.011, F.S.; adding duties of the Department of Health and Rehabilitative Services relating to maternal and child health; requiring the department to establish Healthy Start Care Coordination programs in the county public health units; providing for family outreach workers; requiring screening programs for families identified as being at risk; requiring the provision of services under this section to be consistent with other specified legal provisions and plans; amending s. 383.013, F.S.; adding duties of the Department of Health and Rehabilitative Services relating to prenatal care; amending s. 383.215, F.S.; providing for developmental intervention at hospitals with level II neonatal intensive care units; creating s. 383.216, F.S.; providing for the establishment of prenatal and infant health care coalitions, including establishment and incorporation of local prenatal and infant health care coalitions, and providing for membership, duties, and services; providing for cooperation and assistance from the Department of Health and Rehabilitative Services, and for contribution match percentages; creating s. 383.2161, F.S.; requiring the department annually to compile and analyze risk information and submit a report to the Legislature; providing requirements for the contents of the report; requiring the department to develop and submit to the Legislature a plan for decategorizing certain resources which includes an alternative reimbursement methodology for providers of certain services; amending s. 427.012, F.S.; adding a representative of maternal and child health care providers to the Transportation Disadvantaged Commission; amending s. 395.0335, F.S.; allowing the department to grant additional time for hospitals to become provisional state-sponsored trauma centers under certain circumstances; clarifying which hospitals are eligible to operate as provisional state-sponsored trauma centers; amending s. 395.034, F.S.; clarifying the reimbursement process for state-sponsored trauma centers; revising the effective dates of specified reimbursement rates; amending s. 395.0345, F.S.; clarifying purposes for which such funds may be expended; providing for deposit of funds into the fund; providing appropriations; amending ss. 458.331, 459.015, 461.013, 466.028, F.S., relating to physicians, osteopathic physicians, podiatrists, and dentists; deleting settlement of claims against the practitioner as indicative of "repeated malpractice" and requiring judgments rather than claims against the practitioner to mandate Department of Professional Regulation investigation; specifying grounds for disciplinary action; reenacting ss. 455.241(2), 455.245(3), 458.311(5), 458.313(7), 466.011, F.S., relating to patient records, suspension of practitioner licenses, licensure by examination, licensure by endorsement, and certification for licensure, to incorporate said amendments in references thereto; amending s. 766.106, F.S.; providing for sufficiency of notice to prospective defendants, and reenacting ss. 458.331(9), 459.015(9), F.S., relating to grounds for disciplinary actions against physicians and osteopathic physicians, to incorporate said amendment in references thereto; amending s. 766.205, F.S.; providing for medical records of patients to be furnished to prospective defendants in medical malpractice actions under specified circumstances; amending s. 95.11, F.S.; prescribing time limitations for medical malpractice actions; providing effective dates.

On motions by Senator Malchon, the Senate concurred in the House amendments as amended and the House was requested to concur in the Senate amendments to the House amendments, and in the event the House refused to concur in the Senate amendments, acceded to the request for a conference committee.

CS for SB 632 passed as amended. The vote on passage was:

Yeas—31 Nays—None

CONFEREES ON CS FOR SB 632 APPOINTED

The President appointed Senator Malchon, Chairman; Senators Bankhead, Dudley, Forman and Weinstock.

The action of the Senate was certified to the House.

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has passed with amendment SB 738 and requests the concurrence of the Senate.

John B. Phelps, Clerk

SB 738—A bill to be entitled An act relating to Palm Beach County; amending chapter 75-473, Laws of Florida, as amended; revising membership requirements for the Solid Waste Authority; providing an effective date.

House Amendment 1—On page 2, lines 8-9, strike all of said lines and insert:

Section 2. This act shall take effect October 1, 1991.

Senator Myers moved the following amendments which failed:

Senate Amendment 1 to House Amendment 1—On page 1, strike line 13 and insert:

Section 2. In addition to the members of the Board of County Commissioners, the board of the Solid Waste Authority of Palm Beach County, created by chapter 75-473, Laws of Florida, as amended, shall include two representatives of the municipalities within Palm Beach County appointed by the Palm Beach County legislative delegation, from names submitted by the Palm Beach County Municipal League, all of whom must be elected municipal officials.

Section 3. This act shall take effect October 1, 1991.

Senate Amendment 2 to House Amendment 1—On page 1, strike line 13 and insert:

Section 2. In addition to the members of the Board of County Commissioners, the board of the Solid Waste Authority of Palm Beach County, created by chapter 75-473, Laws of Florida, as amended, shall include two representatives of the municipalities within Palm Beach County appointed by the Palm Beach County legislative delegation, from names submitted by the Palm Beach County Municipal League, all of whom must be elected municipal officials.

Section 3. This act, except for this section which shall take effect upon becoming a law, shall take effect only upon approval by a majority vote of the electors of Palm Beach County voting in a referendum election which shall be called and held by the Board of County Commissioners in Palm Beach County at the next general election or at an earlier special election called for that purpose.

On motion by Senator Weinstock, the Senate concurred in the House amendment.

SB 738 passed as amended and was ordered engrossed and then enrolled. The action of the Senate was certified to the House. The vote on passage was:

Yeas—24 Nays—7

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has passed with amendments CS for SB 1282 and requests the concurrence of the Senate.

John B. Phelps, Clerk

CS for SB 1282—A bill to be entitled An act relating to public lodging and food service establishments; amending s. 509.013, F.S.; removing certain vending machines from the Department of Business Regulation jurisdiction; providing that certain vending machines are excluded from the definition of a "public food service establishment"; revising the definition of a "single complex of buildings"; amending s. 509.032, F.S.; providing for inspection of resort dwellings; amending s. 509.035, F.S.; clarifying language prescribed for use on public health warning signs; amending s. 509.101, F.S.; requiring certain public food service establishments to maintain a registry verifying certain mobile food dispensing vehicle information; amending s. 509.201, F.S.; requiring additional disclosure in certain public displays of lodging rates; exempting resort dwellings from certain advertising requirements; amending s. 509.211, F.S.; expanding the application of certain safety regulations to include all public lodging establishments; amending s. 509.2112, F.S.; expanding the application of certain filing requirements and of certain sanctions for failure to file; amending s. 509.215, F.S.; providing that certain published standards are the ones most recently adopted by the Division of State Fire Marshal of the Department of Insurance; amending s. 509.221, F.S.; exempting resort dwellings from certain sanitary regulations; amending s. 509.241, F.S.; requiring certain public food service establishments to display license numbers in advertisements; amending s. 509.242, F.S.; creating and defining resort dwelling as an additional lodging establishment classification; directing the Division of Hotels and Restaurants of the Department of Business Regulation to study certain issues; providing for a report; amending s. 509.251, F.S.; providing for the licensing of resort dwelling units; amending s. 509.291, F.S.; increasing the membership of the advisory council in the Department of Business Regulation; clarifying the number of voting members; amending s. 509.302, F.S.; authorizing the director of education under certain circumstances to designate funds to support programs in hospitality services; providing for program supervision; providing for rules; providing an appropriation from the Hotel and Restaurant Trust Fund; providing an effective date.

House Amendment 1—On page 15, between lines 20 and 21, insert:

Section 15. Subsection (8) of section 404.056, Florida Statutes, is amended to read:

404.056 Environmental radiation standards and programs; radon protection.—

(8) NOTIFICATION ON REAL ESTATE DOCUMENTS.—By January 1, 1989, notification shall be provided on at least one document, form, or application executed at the time of, or prior to, contract for sale and purchase of any building or execution of a rental agreement for any building. Such notification shall contain the following language:

"RADON GAS: Radon is a naturally occurring radioactive gas that, when it has accumulated in a building in sufficient quantities, may present health risks to persons who are exposed to it over time. Levels of radon that exceed federal and state guidelines have been found in buildings in Florida. Additional information regarding radon and radon testing may be obtained from your county public health unit."

The requirements of this subsection do not apply to any residential transient occupancy, as described in s. 509.013(9), provided that such occupancy is 45 days or less in duration.

(Renumber subsequent sections.)

House Amendment 2—In title, on page 2, line 21, after "rules;" insert: amending s. 404.056, F.S.; exempting certain buildings from radon gas disclosure requirements;

On motions by Senator Diaz-Balart, the Senate concurred in the House amendments.

CS for SB 1282 passed as amended and was ordered engrossed and then enrolled. The action of the Senate was certified to the House. The vote on passage was:

Yeas—30 Nays—None

RETURNING MESSAGES ON HOURS BILLS

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has refused to concur in Senate amendments to CS for HB 2343 and requests that a conference committee be appointed.

The Speaker has appointed the following Representatives to the conference committee: Representatives Jamerson, Davis, Long, Mortham, and Stone.

John B. Phelps, Clerk

CS for HB 2343—A bill to be entitled An act relating to education; amending s. 229.591, F.S.; revising provisions relating to comprehensive revision of Florida's system of school improvement and responsibility; providing intent for a system of school improvement and education accountability; providing requirements and education goals; amending s. 229.592, F.S.; providing for implementation of the system of improvement and accountability; providing duties of the Legislature, Commissioner of Education, Department of Education, and State Board of Education; providing for exceptions to the law; amending ss. 229.593 and 229.594, F.S.; deleting the Commission to Improve Schools and Simplify Education Reports and providing for the Florida Commission on Education Reform and Accountability and duties thereof; amending s. 24.121, F.S.; revising provisions relating to use and distribution of revenues from the sale of lottery tickets; amending s. 120.68, F.S.; providing for judicial review of certain actions; amending s. 228.041, F.S.; providing for definition of the term performance standard; amending ss. 228.0617, 229.551, 229.575, 229.59, and 233.0615, F.S.; conforming language; amending s. 229.512, F.S.; providing an additional duty of the commissioner; amending s. 229.58, F.S.; changing district and school advisory committees to councils and revising certain requirements thereof; amending s. 230.03, F.S.; providing duties of school principals; amending s. 230.23, F.S.; providing duties of school boards for implementation of a system of school improvement and education accountability; providing contents of such system; amending s. 230.33, F.S.; providing related duties of superintendents; amending s. 230.2316, F.S.; revising certain requirements relating to educational alternatives programs; amending s. 231.085, F.S.; providing duties of principals; authorizing the reorganization of the Division of Public Schools; providing for consideration for appointment to the Flor-

ida Commission on Education Reform and Accountability; repealing ss. 229.861, 229.863, 229.865, 229.867, F.S.; relating to Board of Public Schools; providing for review and repeal; providing an effective date.

On motions by Senator Walker, the Senate refused to recede from Senate amendments to **CS for HB 2343** and acceded to the request for a conference committee.

CONFEREES ON CS FOR HB 2343 APPOINTED

The President appointed Senators Walker, Chairman; Gordon, Johnson, Scott and Thurman.

The action of the Senate was certified to the House.

RETURNING MESSAGES—FINAL ACTION

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has passed CS for SB 104, SB 152, CS for SB 438, CS for SB 602, Senate Bills 630, 894, 1050, 1380, CS for SB 1384 and SB 1640.

John B. Phelps, Clerk

The bills contained in the foregoing message were ordered enrolled.

The Honorable Gwen Margolis, President

I am directed to inform the Senate that the House of Representatives has concurred in Senate amendments and passed as amended, House Bills 573, 2075 and CS for HB 2399.

John B. Phelps, Clerk

AMENDMENTS TO SENATE BILLS

CS for SB 60

The Committee on Finance, Taxation and Claims recommended the following amendment which was moved by Senator Beard and adopted:

Amendment 1—On page 2, line 20, after "governments" insert: and utilities

CS for SB 296

Senator Dudley moved the following amendments which were adopted:

Amendment 1—On page 2, strike all of lines 8 and 9 and insert: *continue if the child is between the ages of 18 and 19, and is still in high school, performing in good faith with a reasonable expectation of graduation before the age of 19.*

Amendment 2—On page 5, strike all of lines 10 and 11 and insert: *dependent in fact, is between the ages of 18 and 19, and is still in high school, performing in good faith with a reasonable expectation of graduation before the age of 19*~~, and any crippled child as~~

SB 596

Senator Thomas moved the following amendment which was adopted:

Amendment 1—On page 2, line 8, after "*employee*" insert: *or general counsel*

CS for SB 938

The Committee on Criminal Justice recommended the following amendments which were moved by Senator Casas and adopted:

Amendment 1—On page 10, line 8, strike "921.009" and insert: 921.001

Amendment 2—On page 3, line 5, strike "*or*" and insert: *and*

Senator Casas moved the following amendments which were adopted:

Amendment 3—On page 5, strike all of lines 20-24 and insert:

(c) The Division of Economic and Demographic Research of the Joint Legislative Management Committee shall prepare alternative proposals which revise the statewide sentencing guidelines and submit such proposals to the Senate Committee on Corrections, Probation, and Parole, Senate Committee on Criminal Justice, House Committee on Corrections, and House Committee on Criminal Justice and to the Sentencing Guidelines Commission by November 1, 1991. The commission is *hereby ordered to* ~~shall~~ develop revised statewide sentencing guidelines and provide them to *the members of the Supreme Court,* the President of the Senate, and the Speaker of the House of Representatives by *January 1, 1992* ~~1989~~, which:

Amendment 4—In title, on page 1, line 8, after the semicolon (;) insert: providing for duties of the Division of Economic and Demographic Research of the Joint Legislative Management Committee;

CS for SB 1026

Senator Langley moved the following amendments which were adopted:

Amendment 1—On page 1, between lines 8 and 9, insert:

Section 1. This act may be cited as the "Senator John Hill Motorcycle Helmet Act."

(Renumber subsequent sections.)

Amendment 2—In title, on page 1, line 2, after the semicolon (;) insert: providing a short title;

CS for SB 1116

Senator Weinstock moved the following amendment which was adopted:

Amendment 1—On page 2, lines 30 and 31, and on page 3, lines 1-4, strike all of said lines and renumber subsequent subsections.

CS for SB 1342

Senator Thurman moved the following amendment:

Amendment 1—Strike everything after the enacting clause and insert:

Section 1. Section 550.012, Florida Statutes, 1990 Supplement, is amended to read:

550.012 Additional operating days.—

(1) The Legislature finds that a degree of flexibility in the process of authorizing days of operation for pari-mutuel permitholders will further the public interest by allowing for rational determinations of the number of authorized days that take into account competitive, economic, and fiscal factors. The purpose of this section is to authorize the Florida Pari-mutuel Commission, subject to the guidelines contained in this section, to provide recommendations to the Legislature for additional days of operation in such a flexible and rational manner.

(2) In addition to its other powers and duties, the commission may hear the request of any permitholder licensed pursuant to this chapter or chapter 551 for up to 105 days of operation, *or any facility authorized to conduct intertrack wagering pursuant to s. 550.61(8) for additional days or additional days to conduct intertrack wagering,* in addition to those authorized by law, provided that such requests must be submitted to the commission by *September* ~~October~~ 15 of each year. In considering such requests, the commission shall conduct public hearings. The commission shall submit a report of its findings with recommendations to the Legislature *no later than 60 days prior to the convening of the regular legislative session* ~~by February 1~~ of the following year. In determining whether to recommend the granting of such additional operating days, the commission shall consider:

(a) The impact of the requested additional days on the handle, attendance, and income of permitholders within a 50-mile radius of the requesting permitholder;

(b) The similarities and dissimilarities of competing permitholders within a 50-mile radius of the requesting permitholder;

(c) The impact of the requested additional days on state revenues generated by the pari-mutuel industry; and

(d) The impact on the division as it relates to the division's operating budget and manpower resources.

(3) Any permitholder seeking additional operating days shall submit a request for such days to the commission by *September* ~~October~~ 15 of each year. The request shall contain the following information:

(a) The number of additional days and performances requested;

(b) Projected increase in handle and attendance as a result of such extra days and performances;

(c) Projected increase in state taxes and revenues as a result of such extra days and performances; and

(d) Any other pertinent information as required by division rule.

(4) The division shall review all requests for additional operating days and shall make recommendations to the commission regarding such days. The division may contract with accountants, economists, attorneys, and other persons as may be required to determine the required economic and fiscal impacts of the requested additional days. To ensure that the requests for additional operating days are reviewed in a timely manner by the division, it is exempt from the provisions of s. 287.057 with regard to contracts awarded to review or determine the economic and fiscal impacts of the requested additional days. However, in awarding such contracts, the division shall consider the cost and the ability and resources of the individual or firm to perform the review or study in a competent and timely manner.

(5)(a) Each request for additional operating days shall be accompanied by an application fee to be deposited into the Pari-mutuel Wagering Trust Fund.

(b) The division is authorized to charge the permitholder any anticipated costs incurred by the division in determining whether to grant or deny applications by a permitholder for additional operating days.

(c) The division may, by rule, determine the manner of payment of its anticipated costs and the procedure for filing applications in conjunction with payments of said costs.

(d) The division shall furnish to the applicant an itemized statement of actual costs incurred during the investigation.

(e) In the event there are unused funds at the conclusion of such investigation, such funds shall be returned to the applicant within 60 days thereafter.

(f) In the event actual costs of investigation exceed anticipated costs, the division shall assess the applicant those moneys necessary to recover all actual costs.

(6) The commission shall consider and make final recommendations to the Legislature on each request for additional operating days no later than *60 days prior to the regular legislative session of the following year* ~~February 1 of each year~~.

(7) The division shall adopt rules to implement the provisions of this section.

Section 2. Subsections (2) and (5) of section 550.03, Florida Statutes, 1990 Supplement, are amended to read:

550.03 Charity racing days.—

(2) The proceeds of charity performances shall be paid to qualified beneficiaries selected by the permitholders from an authorized list of charities on file with the division. Eligible charities include any charity which provides evidence of compliance with the provisions of chapter 496 and evidence of possession of a valid exemption from federal taxation issued by the Internal Revenue Service. In addition, the authorized list shall include the Racing Scholarship Trust Fund, the Historic Preservation Trust Fund, major state and private institutions of higher learning, and Florida community colleges. ~~In any racing season, a permitholder may not conduct more than three of the authorized charity days for the benefit of charities other than the Racing Scholarship Trust Fund, major state or private institutions of higher learning, and Florida community colleges.~~

(5) *In determining profit, the permitholder may elect to distribute as proceeds only the amount equal to the state tax that would otherwise be paid to the state if the charity day was conducted as a regular or matinee performance.* ~~In determining profit, the permitholder shall deduct from the revenues the prorated share of operating expenses based upon the number of racing performances conducted during the permitholder's fiscal year. The expenses shall include all expenses reported in the uniform reporting system which are deductible by the permitholder for state or federal income tax purposes, except that no deduction will be allowed for officer and director compensation, interest on capital debt, legal fees, real estate taxes, bad debts, contributions or donations, or overhead expenses charged by a parent organization that are not directly related to the charity racing performance conducted. In no event may the amount paid to the charity be less than the taxes that would otherwise have been paid to the state if the charity racing performance had been conducted as a regular racing performance. The division shall by rule prescribe the form and content of the reports necessary to assure the proper distribution of the proceeds of charity days to the authorized charities.~~

Section 3. Subsection (3) of section 550.09, Florida Statutes, 1990 Supplement, is amended to read:

550.09 Payment of daily license fee and taxes.—

(3) TAX ON HANDLE.—Each permitholder shall pay a tax on contributions to pari-mutuel pools, the aggregate of which is hereinafter referred to as "handle," on races conducted by the permitholder. The tax shall be imposed daily and shall be based on the total contributions to all pari-mutuel pools conducted during the daily performance. In the event that a permitholder is authorized by the Florida Pari-mutuel Commission to conduct and does conduct more than one performance daily, the tax shall be imposed on each performance separately. A "performance" is defined as a series of races conducted consecutively under a single admission charge.

(a) The tax on handle for thoroughbred horse racing, harness horse racing, and quarter horse racing shall be 3.3 percent of the handle in excess of $300,000 for each performance per day, except as provided in paragraphs (b) and (c).

(b) Except as provided in paragraph (c), the tax on handle for thoroughbred horse racing conducted by a permitholder from January 8 through March 6 shall be 3.3 percent of the handle in excess of $175,000 for each performance per day.

(c) The tax on handle for any horse track where the average daily handle on June 4, 1980, is less than $400,000 shall be 3.3 percent of the handle in excess of $500,000 for each performance per day.

(d) The tax on handle for dogracing shall be 7.6 percent of the handle in excess of $25,000 for each performance per day. However, when the handle for the preceding racing season is less than $30 million and $15 million or more, then the tax shall be paid on the handle in excess of $40,000 for each performance per day, and when the handle for the preceding racing season is less than $15 million, then the tax shall be paid on the handle in excess of $50,000 for each performance per day.

(e)1.*a.* The tax on handle for intertrack wagering shall be 3 percent of the handle if the host track is a horse track, 6 percent if the host track is a dog track, and 6 percent if the host track is a jai alai fronton, and shall be deposited into the General Revenue Fund.

b. Any guest track that imposes a surcharge on each winning ticket cashed pursuant to s. 550.633 shall pay an additional tax equal to 5 percent of the surcharge so imposed. Any taxes so imposed shall be deposited into the General Revenue Fund.

2.a. As used in this paragraph:

(I) "Effective tax rate on handle" means the total for each fiscal year of all taxes from live racing paid by the permitholder to the state expressed as a percentage of handle for regular live performances. For the purpose of this definition, the taxes shall include only the tax on breaks, and the tax on handle plus any surtax on handle.

(II) "Total state tax revenue from pari-mutuel wagering" means any revenues collected pursuant to this chapter or chapter 551 which are deposited into or transferred into the General Revenue Fund.

(III) "Fiscal year" means the state fiscal year.

b. The portion of the total state tax revenues from pari-mutuel wagering that is in excess of the total state tax revenues from pari-mutuel wagering in fiscal year 1989-1990 shall be earned each fiscal year, beginning in fiscal year 1990-1991, as a credit against taxes in the following fiscal year to reduce the effective tax rate on handle for each dogracing and jai alai permitholder as provided in sub-subparagraph c. The credit against taxes earned in any fiscal year after 1990-1991 shall be considered as revenue to the General Revenue Fund for the purposes of calculating the tax credit for the following year.

c. The tax credit for each dogracing permitholder or jai alai permitholder shall be based on the handle from live racing on regular perform-

ances in the preceding fiscal year and shall be computed as follows: total handle from live racing at each track or fronton divided by the total handle from live racing at all dog tracks and frontons multiplied by the total tax credit as established in sub-subparagraph b. Each state fiscal year, each dogracing permitholder and each jai alai permitholder shall be authorized to deduct any tax credits earned in the previous fiscal year from any tax due to the General Revenue Fund from live pari-mutuel wagering. In no event shall the tax credit reduce the effective tax rate on handle for the preceding fiscal year below 5.6 percent for any dogracing permitholder or 5.1 percent for any jai alai permitholder. The entire tax credit shall be used each year until the effective tax rate on handle is 5.6 percent for each dogracing and 5.1 percent for each jai alai permitholder. If the effective tax rate on handle of an individual dogracing permitholder is less than 5.6 percent, or an individual jai alai permitholder is less than 5.1 percent, no credit shall be authorized for such permitholder in the following year.

d. At the conclusion of each fiscal year, the division shall determine and report to each permitholder the earned tax credit authorized for the following fiscal year.

Section 4. Subsection (3) of section 550.262, Florida Statutes, 1990 Supplement, is amended to read:

550.262 Horseracing; minimum purse requirement, Florida breeders' and owners' awards.—

(3) Each permitholder conducting *any* ~~a~~ thoroughbred race under the provisions of this chapter, *including any intertrack race taken pursuant to ss. 550.61-550.63 or any interstate simulcast taken pursuant to s. 550.35(2)(b)* shall pay a sum equal to *0.75 percent* ~~the breaks~~ on all pari-mutuel pools conducted during *any such* ~~that~~ race for the payment of breeders' and stallion awards as authorized in this section. *This provision also applies to all Breeder's Cup races conducted outside this state taken pursuant to s. 550.35(2)(b).* The Florida Thoroughbred Breeders' Association is authorized to receive these payments from the permitholders and make payments of awards earned. The Florida Thoroughbred Breeders' Association has the right to withhold up to 10 percent of the permitholder's payments under this section ~~and under s. 550.263~~ as a fee for administering the payments of awards *and for general promotion of the industry*. The permitholder shall remit these payments to the Florida Thoroughbred Breeders' Association by the fifth day of each calendar month for such sums accruing during the preceding calendar month and shall report such payments to the Division of Pari-mutuel Wagering as prescribed by the division. With the exception of the 10-percent fee ~~for administering the payments~~, the moneys paid by the permitholders shall be maintained in a separate, interest-bearing account, and such payments together with any interest earned shall be used exclusively for the payment of breeders' awards and stallion awards in accordance with the following provisions:

(a) The breeder of each Florida-bred thoroughbred horse winning a thoroughbred horserace shall be entitled to an award of up to, but not to exceed, 20 percent of the announced gross purse, including nomination fees, eligibility fees, starting fees, supplementary fees, and moneys added by the sponsor of the race.

(b) The owner or owners of the sire of a Florida-bred thoroughbred horse which wins a stakes race shall be entitled to a stallion award of up to, but not to exceed, 20 percent of the announced gross purse, including nomination fees, eligibility fees, starting fees, supplementary fees, and moneys added by the sponsor of the race.

(c) In order for a breeder of a Florida-bred thoroughbred horse to be eligible to receive a breeder's award, the horse winning the race must have been registered as a Florida-bred horse with the Florida Thoroughbred Breeders' Association, and the Jockey Club certificate for the winning horse must show that the winner has been duly registered as a Florida-bred horse as evidenced by the seal and proper serial number of the Florida Thoroughbred Breeders' Association registry. The Florida Thoroughbred Breeders' Association shall be permitted to charge the registrant a reasonable fee for this verification and registration.

(d) In order for an owner of the sire of a thoroughbred horse winning a stakes race to be eligible to receive a stallion award, the stallion must have been registered with the Florida Thoroughbred Breeders' Association, and the breeding of the registered Florida-bred horse must have occurred in this state. The stallion must be standing permanently in this state or, if the stallion is dead, must have stood permanently in this state for a period of not less than 1 year immediately prior to its death. The removal of a stallion from this state for any reason, other than exclusively for prescribed medical treatment, shall render the owner or owners of the stallion ineligible to receive a stallion award under any circumstances for offspring sired prior to removal; however, if a removed stallion is returned to this state, all offspring sired subsequent to the return shall make the owner or owners of the stallion eligible for the stallion award but only for those offspring sired subsequent to such return to this state. The Florida Thoroughbred Breeders' Association shall maintain complete records showing the date the stallion arrived in this state for the first time, whether or not the stallion remained in the state permanently, the location of the stallion, and whether the stallion is still standing in this state and complete records showing awards earned, received, and distributed. The association may charge the owner, owners, or breeder a reasonable fee for this service.

(e) A permitholder conducting a thoroughbred horse race under the provisions of this chapter shall, within 30 days after the end of the race meet during which the race is conducted, certify to the Florida Thoroughbred Breeders' Association such information relating to the thoroughbred horses winning a stakes or other horserace at the meet as may be required to determine the eligibility for payment of breeders' awards and stallion awards.

(f) The Florida Thoroughbred Breeders' Association shall maintain complete records showing the starters and winners in all races conducted at thoroughbred tracks in this state; shall maintain complete records showing awards earned, received, and distributed; and may charge the owner, owners, or breeder a reasonable fee for this service.

(g) The Florida Thoroughbred Breeders' Association shall annually establish a uniform rate and procedure for the payment of breeders' and stallion awards and shall make breeders' and stallion award payments in strict compliance with the established uniform rate and procedure *plan*. The plan may set a cap on winnings and may limit, exclude, or defer payments to certain classes of races, such as the Florida stallion stakes races, in order to assure that there are adequate revenues to meet the proposed uniform rate. *Such plan shall include proposals for the general promotion of the industry*. Priority shall be placed upon imposing such restrictions in lieu of allowing the uniform rate to be less than 15 percent of the total purse payment. The uniform rate *and* procedure *plan* shall be approved by the Florida Pari-mutuel Commission before implementation. In the absence of an approved plan and procedure, the authorized rate for breeders' and stallion awards shall be 15 percent of the announced gross purse for each race. Such purse shall include nomination fees, eligibility fees, starting fees, supplementary fees, and moneys added by the sponsor of the race. In the event that the funds in the account for payment of breeders' and stallion awards are not sufficient to meet all earned breeders' and stallion awards, those breeders and stallion owners not receiving payments shall have first call on any subsequent receipts in that or any subsequent year.

(h) The Florida Thoroughbred Breeders' Association shall keep accurate records showing receipts and disbursements of such payments and shall annually file a full and complete report to the Division of Pari-mutuel Wagering reflecting such receipts and disbursements and the sums withheld for administration. The Division of Pari-mutuel Wagering may audit the records and accounts of the Florida Thoroughbred Breeders' Association to determine that payments have been made to eligible breeders and stallion owners in accordance with the provisions of this section.

(i) In the event that the Florida Pari-mutuel Commission finds that the Florida Thoroughbred Breeders' Association has not complied with any provision of this section, the commission may order the association to cease and desist from receiving funds and administering funds received under this section ~~and under s. 550.263~~. In the event that the commission enters such an order, the permitholder shall make the payments authorized in this section ~~and s. 550.263~~ to the Division of Pari-mutuel Wagering for deposit into the Pari-mutuel Wagering Trust Fund; and any funds in the Florida Thoroughbred Breeders' Association account shall be immediately paid to the Division of Pari-mutuel Wagering for deposit to the Pari-mutuel Wagering Trust Fund. The Florida Pari-mutuel Commission shall authorize payment from these funds to any breeder or stallion owner entitled to an award which had not been previously paid by the Florida Thoroughbred Breeders' Association in accordance with the applicable rate.

Section 5. Section 550.263, Florida Statutes, is amended to read:

550.263 Horseracing; distribution of abandoned interest in or contributions to pari-mutuel pools.—

(1) *Except as provided in subsection (3),* all moneys or other property represented by any unclaimed, uncashed, or abandoned pari-mutuel ticket which has remained in the custody of or under the control of any horseracing permitholder authorized to conduct pari-mutuel pools in this state for a period of 1 year from the date the pari-mutuel ticket was issued, when the rightful owner or owners thereof have made no claim or demand for such money or other property within that period, is hereby declared to have escheated to or to escheat to, and to have become the property of, the state.

(2) All moneys or other property which has escheated to and become the property of the state as provided herein and which is held by a permitholder authorized to conduct pari-mutuel pools in this state shall be paid annually by the permitholder to the recipient designated in this subsection within 60 days after the close of the race meeting of the permitholder. Section 550.164 notwithstanding, such moneys shall be paid by the permitholder as follows:

~~(a) Funds from any thoroughbred races shall be paid to the Florida Thoroughbred Breeders' Association and shall be used for the payment of breeders' awards and stallion awards as provided for in s. 550.262.~~

(a)~~(b)~~ Funds from any harness horse races shall be paid to the Florida Standardbred Breeders and Owners Association and shall be used for the payment of breeders' awards, stallion awards, stallion stakes, additional purses, and prizes for, and for the general promotion of owning and breeding of, Florida-bred standardbred horses, as provided for in s. 550.262.

(b)~~(c)~~ Except as provided in paragraphs *(c)* ~~(d)~~ and *(d)* ~~(e)~~, funds from quarter horse races shall be paid to the Florida Quarter Horse Breeders and Owners Association and shall be allocated solely for supplementing and augmenting purses and prizes and for the general promotion of owning and breeding of racing quarter horses in this state, as provided for in s. 550.262.

(c)~~(d)~~ Funds for Appaloosa races conducted under a quarter horse racing permit shall be deposited into the Florida Quarter Horse Racing Promotion Trust Fund in a special account to be known as the "Florida Appaloosa Racing Promotion Fund" and shall be used for the payment of breeders' awards and stallion awards as provided for in s. 550.266.

(d)~~(e)~~ Funds for Arabian horse races conducted under a quarter horse racing permit shall be deposited into the Florida Quarter Horse Racing Promotion Trust Fund in a special account to be known as the "Florida Arabian Horse Racing Promotion Fund" and shall be used for the payment of breeders' awards and stallion awards as provided for in s. 550.267.

(3) Uncashed tickets and breaks on live racing conducted by thoroughbred permitholders shall be retained by the permitholder conducting the live race.

Section 6. Legislative intent.—It is the intent of the Legislature that the exemptions set forth in ss. 550.2635(6) and 550.26355 apply only to races during the Breeders' Cup Meet for which the purses are paid or supplied directly by the Breeders' Cup Limited. Breeders' awards requirements of ss. 550.262 and 550.62(2)(a) are applicable to all other races conducted during the Breeders' Cup Meet.

Section 7. Subsection (2) of section 550.356, Florida Statutes, 1990 Supplement, is amended to read:

550.356 Broadcasts to and from out-of-state locations; commingling of pari-mutuel pools authorized.—

(2) During its race meet, any Florida horse track may receive broadcasts of horseraces conducted at other horse tracks located outside of this state and may accept wagers on such races. The following provisions shall be applicable to the acceptance of wagers on races broadcast under this section:

(a) All broadcasts must comply with the provisions of the Interstate Horseracing Act of 1978, 92 Stat. 1811, 15 U.S.C. s. 3001 et seq. All Florida horse tracks shall have standing to enforce the provisions of this subsection in the courts of this state.

(b) Wagers accepted at the Florida horse track may be, but are not required to be, included in the pari-mutuel pools of the out-of-state horse track which broadcasts the race. Notwithstanding any contrary provisions of this chapter, if the Florida horse track elects to include wagers accepted on such races in the pari-mutuel pools of the out-of-state horse track which broadcasts the race, then, from the amount wagered by patrons at the Florida horse track and included in the pari-mutuel pools of the out-of-state horse track, the Florida horse track, as the commission, shall deduct a percentage equal to the percentage deducted from the amount wagered at the out-of-state racetrack as the commission authorized by the laws of the jurisdiction exercising regulatory authority over the out-of-state horse track.

(c) All forms of pari-mutuel wagering shall be allowed on races broadcast under this section, and all money wagered by the patrons at the Florida horse track on such races shall be subject to taxation under s. 550.09. The provisions of s. 550.262 are not applicable to wagers on races broadcast under this section. If the Florida horse track, which accepts wagers on races broadcast under this section, has made the election authorized *for capital improvements* ~~by s. 550.16(2)(i)~~, then, with regard to such wagers only, any additional commission generated thereby shall be retained by the Florida horse track as commission. Similarly, the commission shall be increased by breaks and uncashed tickets for wagers on races broadcast under this section, notwithstanding any contrary provision of this chapter.

(d) No Florida horse track shall be required to make payment to horse owners or any horsemen's association in excess of 50 percent of the net proceeds retained by the Florida horse track on account of wagering on the out-of-state broadcast under this section. For the purposes of this subsection, net proceeds shall mean the amount remaining after payment of taxes under s. 550.09, payment for broadcast rights to the out-of-state horse track, and payment of expenses reasonably related to the promotion and transmission of the broadcast, the transmission and exchange of wagering information, and, if applicable, the commingling of pari-mutuel pools.

(e) The division shall be authorized to promulgate such rules as are necessary to facilitate the commingling of pari-mutuel pools and to regulate the distribution of net proceeds between the Florida horse track and horsemen's associations.

(f) Greyhound tracks and jai alai frontons shall have the same privileges as provided in this section to horse tracks, as applicable, subject to the rules promulgated in paragraph (e).

Section 8. Subsection (8) is added to section 550.52, Florida Statutes, 1990 Supplement, to read:

550.52 Florida thoroughbred racing; certain permits; operating days.—

(8)(a) Subject to the conditions set forth in paragraph (b), on or before March 31 of each year, any permitholder may notify the division that that permitholder does not intend to operate any racing days during the Florida Thoroughbred Racing Season commencing on the following June 1, which notification is irrevocable once made.

(b) The provisions of subsection (2) notwithstanding, if a permitholder exercises the privilege granted in paragraph (a), that permitholder shall not be subject to any disability or loss of franchise rights only if the notification to the division described in paragraph (a) is accompanied by a cashier's check payable to the Division of Pari-Mutuel Wagering in the amount of $25,000, which payment represents a partial recovery of the loss in pari-mutuel revenue occasioned by the permitholder's failure to operate.

(c) With regard to the Florida Thoroughbred Racing Season commencing June 1, 1991, only, all of the provisions of paragraphs (a) and (b) apply except that the notification described in paragraph (a) may be given on or before May 31, 1991.

Section 9. Subsections (3) and (8) of section 550.61, Florida Statutes, 1990 Supplement, are amended, and subsection (10) is added to that section, to read:

550.61 Intertrack wagering.—

(3) If a permitholder elects to broadcast its signal to any permitholder in this state, any permitholder that is eligible to conduct intertrack wagering under the provisions of ss. 550.60-550.63 is entitled to receive the broadcast and conduct intertrack wagering under this section. A person may not restrain or attempt to restrain any permitholder

*that is otherwise authorized to conduct intertrack wagering from receiving the signal of any other permitholder or sending its signal to any per*mitholder. ~~A permitholder may elect to send its signal to any permitholder, and such permitholder may then take wagers under this section.~~

(8)*(a) Upon application to the division, on or before January 4 of each year, any quarter horse permitholder that has conducted at least 15 days of thoroughbred horse sales at a permanent sales facility for at least 3 consecutive years, and conducted at least one day of thoroughbred racing pursuant to s. 550.50, with a purse structure of at least $250,000 per year for 2 consecutive years prior to such application, shall be issued a license to conduct intertrack wagering for thoroughbred racing for up to 21 days in connection with thoroughbred sales, and an additional 100 days to conduct intertrack wagering at such permanent sales facility between November 1 and May 8 of the following year, subject to conditions set forth in this subsection, provided that no more than one such license shall be issued.*

(b) If more than one permitholder applies, the Florida Pari-mutuel Commission shall determine which permitholder shall be granted the license. In making its determination, the commission shall consider the length of time the permitholder has been conducting thoroughbred horse sales in this state, the length of time the applicant has had a permanent location in this state, and the volume of sales of thoroughbred horses in this state, giving the greater weight to the applicant that meets these criteria.

(c) The applicant must comply with the provisions of ss. 550.12 and 550.181.

(d) The applicant, prior to conducting intertrack wagering, must be licensed as a concessionaire pursuant to ss. 550.10. The license shall be valid from February 15 of the year granted and shall expire February 15 of the following year. However, upon application following the effective date of this subsection, the license shall be issued for the remainder of this year through and including February 15, 1992.

(e) Intertrack wagering under this subsection may not be conducted within 50 miles of any greyhound race track that has conducted a full schedule of live racing prior to June 1, 1990.

(f) For each year such quarter horse permitholder must obtain the license set forth in paragraph (d), any provisions relating to suspension or revocation of a quarter horse permit for failure to conduct live quarter horse racing shall not be applicable.

(g) Intertrack wagering under this subsection may only be conducted on thoroughbred horseracing, and intertrack wagering under this subsection may not be conducted on evening performances. ~~Upon application to the division, intertrack wagering shall be permitted at a permanent location for a maximum of 21 days at thoroughbred sales approved by the Florida Thoroughbred Breeders' Association, Inc., provided such sale is conducted no closer than 50 miles of any greyhound race track which has conducted a full schedule of live racing prior to June 1, 1990. The applicant shall be licensed as a concessionaire pursuant to s. 550.10 and shall be considered a guest track for purposes of intertrack wagering and the provisions of this subsection. All receipts due the guest track shall, after deducting the expenses of conducting intertrack wagering, be paid to the Florida Thoroughbred Breeders' Association, Inc., to be used for additional breeders' awards.~~

(10) A greyhound permitholder conducting intertrack wagering as a host track shall pay 70 percent of the amount set forth in s. 550.162(2) for greyhound purses on intertrack wagers.

Section 10. Section 550.62, Florida Statutes, 1990 Supplement, is amended to read:

550.62 Intertrack wagering; purses; breeder's awards.—If a host track is a horse track:

(1) A host track *racing under either a thoroughbred or quarter horse permit* shall pay an amount equal to *6.125* ~~7~~ percent of all wagers placed pursuant to the provisions of s. 550.61, as purses during its current race meet. *A host track racing under a harness permit shall pay an amount equal to 7 percent of all wagers placed pursuant to the provisions of s. 550.61, as purses during its current race meet.* In the event a host track underpays or overpays purses required by this section and s. 550.262, the provisions of s. 550.262 shall apply to the overpayment or underpayment.

(2) ~~An amount equal to 1 percent~~ Of all wagers placed pursuant to the provisions of s. 550.61 ~~shall be paid~~:

(a) If the host track is a thoroughbred track, *an amount equal to 0.75 percent shall be paid* to the Florida Thoroughbred Breeders' Association, Inc., for the payment of breeder's awards;

(b) If the host track is a harness track, *an amount equal to 1 percent shall be paid* to the Florida Standardbred Breeders and Owners Association, Inc., for the payment of breeder's awards, stallion awards, stallion stakes, additional purses, and prizes for, and the general promotion of owning and breeding Florida-bred standardbred horses; or

(c) If the host track is a quarter horse track, *an amount equal to 1 percent shall be paid* to the Florida Quarter Horse Breeders and Owners Association, Inc., for the payment of breeder's awards and general promotion.

(3) The payment to a breeder's organization shall be combined with any other amounts received by the respective breeder's and owner's associations as so designated. Each breeder's and owner's association receiving these funds shall be allowed to withhold the same percentage as set forth in s. 550.262 to be used for administering the payment of awards and for the general promotion of their respective industries. In the event the total combined amount received for thoroughbred breeder's awards exceeds 15 percent of the purse required to be paid under subsection (1), the breeder's and owner's association, as so designated, notwithstanding any other provision of law, shall submit a plan to the commission for approval that would utilize the excess funds in promoting the breeding industry by increasing the purse structure for Florida-breds. Preference shall be given to the track generating such excess.

(4) If thoroughbred intertrack wagering is taken at any dog track or jai alai fronton, which is located within 25 miles of any thoroughbred permitholder that is not conducting live racing, the host track shall pay to such thoroughbred permitholder an amount equal to one-half of the purses required under subsection (1), which shall be deducted from the purses required to be paid by the host track. Such amount shall be used by the permitholder to pay purses during its next race meet.

Section 11. Subsections (1) and (9) of section 550.63, Florida Statutes, 1990 Supplement, are amended to read:

550.63 Intertrack wagering; guest track payments; accounting rules.—

(1) All guest tracks which are eligible to receive broadcasts and accept wagers on *horse* races from a host track *racing under either a thoroughbred or quarter horse permit* shall be entitled to payment of 7 ~~5~~ percent of the total contributions to the pari-mutuel pool on wagers accepted at the guest track. *All guest tracks that are eligible to receive broadcasts and accept wagers on greyhound races or jai alai games from a host track other than a thoroughbred or harness permitholder shall be entitled to payments of 5 percent of the total contributions to the daily pari-mutuel pool on wagers accepted at the guest track. All guest tracks that are eligible to receive broadcasts and accept wagers on horse races from a host track racing under a harness horse permit shall be entitled to a payment of 5 percent of the total contributions to the daily pari-mutuel pool on wagers accepted at the guest track.* However, if a guest track is a horserace permitholder which accepts intertrack wagers during its current race meet, then one-half of the payment provided in this subsection *and s. 550.635* shall be paid as purses during its current race meet. *However, when the host track is a thoroughbred permitholder and the guest track is also a thoroughbred permitholder and accepts thoroughbred intertrack wagers during its current race meet, one-third of the payment provided in this subsection shall be paid as purses during its current race meet, and one-third of the payment required of the host track to be paid as purses shall be remitted to the guest track to be paid during its current race meet.* ~~If the guest track is a greyhound permitholder which accepts intertrack wagers during its current race meet, then one-fifth of the payment provided in this subsection shall be paid as purses during its current race meet.~~

(9) A host track which has contracted with an out-of-state horse track to broadcast live races conducted at such out-of-state horse track pursuant to s. 550.35(3) may broadcast such out-of-state races to any guest track and accept wagers thereon in the same manner as is provided in s. 550.35. *Notwithstanding the provisions of ss. 550.62(1), 550.62(2)(a), and 550.63(1), the proceeds that are retained by a thoroughbred host track from the take-out on a race broadcast under this subsection shall be distributed as follows:*

(a) Of the total intertrack handle on the broadcast 0.75 percent shall be deducted from the proceeds and paid to the Florida Thoroughbred Breeders' Association, to be used as set forth in s. 550.62(2)(a);

(b) One-third of the remainder of such proceeds shall be paid to the guest track;

(c) One-third of the remainder of such proceeds shall be retained by the host track; and

(d) One-third of the remainder shall be paid by the host track as purses at the host track.

Section 12. Section 550.663, Florida Statutes, is created to read:

550.633 Surcharge.—Any guest track that accepts intertrack wagers may collect and retain a surcharge on any intertrack pool in an amount not to exceed 3 percent of each winning pari-mutuel ticket cashed.

Section 13. Section 550.635, Florida Statutes, is created to read:

550.635 Intertrack wagering; purses when host track is harness racetrack.—A harness race permitholder host track may pay any guest track that receives broadcasts and accepts wagers on races from the host track an additional percentage of the total contribution to the pari-mutuel pool on wagers accepted at that guest track as a supplement to the payment authorized in s. 550.63. A harness race permitholder host track that supplements payments to a guest track may reduce the account available for payment of purses during its current race meet by 50 percent of the supplemental amount paid to the guest track, but the total reduction shall not exceed 1 percent of the intertrack wagers placed on races which are part of the regular ontrack program of the host track during its current race meet pursuant to s. 550.61.

Section 14. Section 550.64, Florida Statutes, 1990 Supplement, is amended to read:

550.64 Applicability of related laws.—All provisions of this chapter or chapter 551 shall be applicable to ss. 550.60-550.63 where consistent with this act; however, the provisions of ss. 550.031, 550.04, 550.05, 550.06, 550.08, 550.09(1) and (2), *550.16 as it relates to capital improvements,* 550.17, 550.18, 550.262(2)(a) and (c), (3), (4), and (5), as to payment of breaks; s. 550.263, as to the payment of escheats; and s. 550.2634, shall not be applicable to the provisions of ss. 550.60-550.63.

Section 15. Section 551.1535, Florida Statutes, is created to read:

551.1535 Jai Alai Tournament of Champions Meet.—

(1) Notwithstanding any provision of this chapter or chapter 550, there is created a special jai alai meet which shall be designated as the "Jai Alai Tournament of Champions Meet" and which shall be hosted by the Florida jai alai permitholders selected by the National Association of Jai Alai Frontons, Inc., to conduct the meet. The meet shall consist of three qualifying performances and a final performance, each of which is to be conducted on different days. Upon the selection of the Florida permitholders for the meet, and upon application by the selected permitholders, the Division of Pari-mutuel Wagering shall issue a license to each of the selected permitholders to operate the meet. The meet may be conducted during a season in which the permitholders selected to conduct the meet are not otherwise authorized to conduct a meet. If the permitholders conduct this meet during their regular seasons, all performances at this meet shall apply towards any minimum number of performance requirements that may exist.

(2) Qualifying performances and the final performance of the tournament shall be held at different locations throughout the state and the permitholders selected shall be under different ownership to the extent possible.

(3) Notwithstanding any provision of s. 551.06, each of the permitholders licensed to conduct performances comprising the Jai Alai Tournament of Champions Meet shall pay no taxes on the live handle or the handle under s. 550.09 for any performance conducted by the permitholder as part of the Jai Alai Tournament of Champions Meet. The provisions of this subsection apply to a maximum of four performances.

(4) The Jai Alai Tournament of Champions Meet permitholders shall also receive a credit against the taxes, otherwise due and payable under s. 551.06, generated during the permitholders' next ensuing regular meet. This credit shall be in the aggregate amount of $150,000, shall be prorated equally between the permitholders, and shall be used by the permitholders solely to supplement awards for the performance conducted during the Jai Alai Tournament of Champions Meet.

(5) In addition to the credit authorized in subsection (4), the Jai Alai Tournament of Champions Meet permitholders shall receive a credit against the taxes, otherwise due and payable under s. 551.06, generated during the permitholders' next ensuing regular meet, in an amount not to exceed the aggregate amount of $150,000, which shall be prorated equally between the permitholders, and shall be used by the permitholders for such capital improvements and extraordinary expenses, including marketing expenses, as may be necessary for the operation of the meet. The determination of the amount to be credited shall be made by the commission upon application of the permitholders.

(6) Notwithstanding any provision of this section to the contrary, any Florida permitholder who is to conduct a performance which is a part of the Jai Alai Tournament of Champions Meet for 1992 shall not be required to apply for the license for that meet if it is to be run during the regular season for which such permitholder has a license.

(7) The permitholder shall be entitled to the permitholder's pro rata share of the $150,000 tax credit provided in subsection (5) without having to make application, so long as appropriate documentation to substantiate the permitholder's expenditures for the purposes outlined in that subsection is provided to the commission within 30 days following the Jai Alai Tournament of Champions Meet.

(8) No Jai Alai Tournament of Champions Meet shall exceed 4 days in any calendar year and no more than one performance shall be conducted on any 1 day of the meet.

(9) The provisions of this section shall prevail over any conflicting provisions of this chapter or chapter 550.

Section 16. Subsections (2), (3), (4), and (5) of section 550.2635, Florida Statutes; subsections (2), (3), (4), and (9) of section 550.2636, Florida Statutes; subsections (2), (3), (4), and (5) of section 550.1635, Florida Statutes, as created by section 18 of chapter 90-352, Laws of Florida; and subsections (3), (4), (5), and (7) of section 551.1535, Florida Statutes, as created by this act, are repealed effective December 1, 1992. Any tax credits accrued prior to December 1, 1992, as a result of these sections shall be taken during the permitholder's next ensuing regular meet, even if that meet takes place after December 1, 1992. The permitholder shall take the credit subject to a final audit by the Division of Pari-mutuel Wagering of the Department of Business Regulation, and any overpayment shall be refunded to the division within 10 days after the permitholder receives notice of the overpayment.

Section 17. This act shall take effect upon becoming a law.

Senator Thurman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1A—On page 8, line 26, after "each" insert: *horseracing*

Senator Thurman moved the following amendment to **Amendment 1**:

Amendment 1B—On page 17, between lines 14 and 15, insert:

Section 8. Section 550.51, Florida Statutes, 1990 Supplement, is amended to read:

550.51 Sunday horseracing, harness racing, greyhound racing, and jai alai operation.—

(1) Notwithstanding any other provision of law, a horseracing, harness racing, greyhound racing, or jai alai permitholder may operate on Sundays during its season subject to the limitations of this section. ~~A permitholder that operates on Sunday shall select another day of the week on which it will not operate, so that no permitholder operates for more than 6 days in any week.~~ No thoroughbred horse racetrack, greyhound racetrack, or jai alai fronton may commence operation on a Sunday earlier than 12:00 noon, and no harness racetrack may commence racing on a Sunday earlier than 7:00 p.m. ~~This section shall not be construed to affect the number of authorized racing days of any horseracing, harness racing, greyhound racing, or jai alai permitholder.~~ No dog track or jai alai fronton shall be permitted to conduct consecutive afternoon matinee performances on Saturday and Sunday, if such dog track or jai alai fronton is located within 25 miles of a *thoroughbred or harness* horse racetrack *that* ~~which~~ is licensed to conduct racing *and pays taxes under the provision of s. 550.04(3)(a) or (b).*

(2) Each dog racing, jai alai, or harness horse racing permitholder operating 6 evening performances in a single week is hereby authorized to conduct one additional evening performance during that week during the 1991-92 operational season upon approval by the Florida Pari-mutuel Commission. In no event shall the total number of additional evening performances for each permitholder exceed one additional evening performance in any week it otherwise operates six other evening performances authorized in s. 550.0121. Any permitholder seeking additional operating evening performances shall submit a request to the commission for such additional evening performances no later than July 31, 1991, and the commission shall hear and render a decision within 60 days of such request. Prior to approving any additional evening performances pursuant to this subsection, the commission shall consider the criteria provided in S. 550.012(2). For a permitholder to continue operation of these performances, after the 1991-92 operational season, the permitholder shall request approval by the commission pursuant to s. 550.012 and be authorized pursuant to s. 550.0121.

(Renumber subsequent sections.)

Senator Thurman moved the following substitute amendment for **Amendment 1B** which was adopted:

Amendment 1C—On page 17, between lines 14 and 15, insert:

Section 8. Section 550.51, Florida Statutes, 1990 Supplement, is amended to read:

550.51 Sunday horseracing, harness racing, greyhound racing, and jai alai operation.—

(1) Notwithstanding any other provision of law, a horseracing, harness racing, greyhound racing, or jai alai permitholder may operate on Sundays during its season subject to the limitations of this section. *This subsection shall not require a jai alai player to perform on more than 6 consecutive days of any given week.* ~~A permitholder that operates on Sunday shall select another day of the week on which it will not operate, so that no permitholder operates for more than 6 days in any week.~~ No thoroughbred horse racetrack, greyhound racetrack, or jai alai fronton may commence operation on a Sunday earlier than 12:00 noon, and no harness racetrack may commence racing on a Sunday earlier than 7:00 p.m. ~~This section shall not be construed to affect the number of authorized racing days of any horseracing, harness racing, greyhound racing, or jai alai permitholder.~~ No dog track or jai alai fronton shall be permitted to conduct consecutive afternoon matinee performances on Saturday and Sunday, if such dog track or jai alai fronton is located within 25 miles of a *thoroughbred or harness* horse racetrack *that* ~~which~~ is licensed to conduct racing *and pays taxes under the provisions of s. 550.09(3)(a) or (b).*

(2) Notwithstanding the number of performances enumerated in section 550.0121, each dog racing, jai alai, or harness horse racing permitholder operating 6 evening performances in a single week is hereby authorized to conduct one additional evening performance during that week during the 1991-92 operational season upon approval by the Florida Pari-mutuel Commission. In no event shall the total number of additional evening performances for each permitholder exceed one additional evening performance in any week it otherwise operates six other evening performances authorized in s. 550.0121. Any permitholder seeking additional operating evening performances shall submit a request to the commission for such additional evening performances no later than July 31, 1991, and the commission shall hear and render a decision within 60 days of such request. Prior to approving any additional evening performances pursuant to this subsection, the commission shall consider the criteria provided in s. 550.012(2). For a permitholder to continue operation of these performances, after the 1991-92 operational season, the permitholder shall request approval by the commission pursuant to s. 550.012 and be authorized pursuant to s. 550.0121.

(Renumber subsequent sections.)

Senator Thurman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1D—On page 18, line 16, after "section" and before the period (.) insert: *provided however, that the host track may require a guest track within 25 miles of another permitholder to receive in any week at least 60 percent of the live races that the host track is making available on the days that the guest track is otherwise operating live races or games. A host track may require a guest track not operating live races or games and within 25 miles of another permitholder to accept within any week at least 60 percent of the live races that the host track is making available.*

Amendment 1 as amended was adopted.

Senator Thurman moved the following amendment:

Amendment 2—In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to pari-mutuels; amending s. 550.012, F.S.; authorizing the Pari-mutuel Commission to grant additional days to certain permitholders; changing dates for issuance of requests for additional days; amending s. 550.03, F.S.; allowing permitholders to elect to distribute certain amounts as proceeds on charity days; removing a limitation on the use of proceeds from charity days; amending s. 550.09, F.S.; imposing an additional tax on guest tracks that impose a surcharge on certain winning tickets; amending s. 550.262, F.S.; requiring the permitholders conducting certain thoroughbred races to pay a specific sum, as breeders' and stallion awards, on all pari-mutuel pools conducted during such races; providing a requirement for the uniform rate and procedure plan of the Florida Thoroughbred Breeders' Association; amending s. 550.263, F.S.; providing that uncashed tickets and breakage tax on live racing conducted by thoroughbred permitholders shall be retained by such permitholder; providing legislative intent with respect to the exemptions set forth in ss. 550.2635(6) and 550.26355, F.S.; amending s. 550.356, F.S.; authorizing certain horse tracks that have made an election authorized for capital improvements to retain additional commission; amending s. 550.52, F.S.; providing for notification that a permitholder does not intend to operate any racing days; providing for a payment to cover part of the loss to the state; amending s. 550.61, F.S.; prohibiting a permitholder that elects to broadcast its signal from entering into an exclusive agreement with a permitholder eligible to conduct intertrack wagering; authorizing additional racing days to certain quarter horse permitholders; providing that provisions relating to the suspension or revocation of a quarter horse permit are inapplicable under certain conditions; placing restrictions on intertrack wagering; amending s. 550.62, F.S.; changing percentages that horseracing host tracks must pay as purses to certain permitholders; amending s. 550.63, F.S.; changing the percentage that guest tracks are paid on intertrack wagering on certain horse races, greyhound races, and jai alai games; providing for distributing certain proceeds retained by a thoroughbred host track; creating s. 550.633, F.S.; providing for a surcharge on certain winning tickets; creating s. 550.635, F.S.; providing for an additional percentage that may be paid by a harness track race permitholder to any guest track that receives broadcasts and accepts wagers on races from the host track; amending s. 550.64, F.S.; providing applicability of related laws; creating s. 551.1535, F.S., establishing the Jai Alai Tournament of Champions Meet; providing for the repeal of ss. 550.2635(2), (3), (4), (5), 550.2636(2), (3), (4), (9), 550.1635(2), (3), (4), (5), 551.1535(3), (4), (5), (7), F.S.; allowing permitholders to take certain tax credits accrued under the repealed provisions; providing for an audit and for the repayment of certain overpayments; providing an effective date.

Senators Childers and Thurman offered the following amendment to **Amendment 2** which was moved by Senator Thurman and adopted:

Amendment 2A—In title, on page 2, line 10, after "commission;" insert: amending s. 550.51, F.S.; authorizing a permitholder to operate 7 days per week; authorizing the Pari-mutuel Commission to approve additional evening performances;

Amendment 2 as amended was adopted.

CS for SB 1440

Senators Kirkpatrick and Brown offered the following amendments which were moved by Senator Brown and adopted:

Amendment 1—On page 1, line 31, after "*Fund*" insert: *also*

Amendment 2—On page 2, line 2, after "*watercraft*" insert: *which*

CS for SB 1662

Senator Bankhead moved the following amendment:

Amendment 1—On page 10, between lines 2 and 3, insert:

Section 5. Subsection (1) of section 39.042, Florida Statutes, 1990 Supplement, is amended to read:

39.042 Use of detention.—

(1) All determinations and court orders regarding the use of secure, nonsecure, or home detention shall be based primarily upon findings that the child:

(a) Presents a substantial risk of not appearing at a subsequent hearing;

(b) Presents a substantial risk of inflicting bodily harm on others as evidenced by recent behavior;

(c) Presents a history of committing a serious property offense prior to adjudication, disposition, or placement; ~~or~~

(d) Requests protection from imminent bodily harm; *or*.

(e) Is charged with a felony or nontraffic related misdemeanor and has had three prior felony adjudications within the past 24 months.

Section 6. Subsection (2) of section 39.044, Florida Statutes, 1990 Supplement, is amended to read:

39.044 Detention.—

(2) Subject to the provisions of subsection (1), a child taken into custody and placed into nonsecure or home detention care or detained in secure detention care prior to a detention hearing may continue to be detained by the court if:

(a) The child is alleged to be an escapee or an absconder from a commitment program, a community control program, furlough, or aftercare supervision, or the child is wanted in another jurisdiction for an offense which, if committed by an adult, would be a felony;

(b) The child has been charged with a delinquent act or violation of law and requests in writing through legal counsel to be detained for protection from an imminent physical threat to his personal safety;

(c) The child is charged with a capital felony, life felony, felony of the first degree, felony of the second degree, or a felony that is also a crime of violence; ~~or~~

(d) The child is charged with a serious property crime as described in s. 810.02(2) or (3) or s. 812.014(2)(c)4., any offense involving the use of a firearm, or any second-degree or third-degree felony involving a violation of chapter 893, and:

1. He has a record of failure to appear at court hearings after being properly notified in accordance with the Rules of Juvenile Procedure;

2. He has a record of law violations prior to court hearings;

3. He has already been detained or has been released and is awaiting final disposition of his case; or

4. He has a record of violent conduct resulting in physical injury to others; *or*.

(e) The child is charged with a felony or nontraffic related misdemeanor and has had three prior felony adjudications within the past 24 months.

A child who meets these criteria and who is ordered to be detained pursuant to this subsection shall be given a hearing within 24 hours after being taken into custody. The purpose of the detention hearing is to determine the existence of probable cause that the child has committed the delinquent act or violation of law with which he is charged and the need for continued detention. The court shall utilize the results of the risk assessment performed by the intake counselor or case manager and, based on the criteria in this subsection, shall determine the need for continued detention. A child placed into secure, nonsecure, or home detention care may continue to be so detained by the court pursuant to this subsection. If the court orders a placement more restrictive than indicated by the results of the risk assessment instrument, the court shall state, in writing, clear and convincing reasons for such placement.

(Renumber subsequent section.)

SB 1838

The Committee on Health and Rehabilitative Services recommended the following amendment which was moved by Senator Weinstock and adopted:

Amendment 1—On page 2, strike all of lines 23-27 and insert: *the application under subparagraph (a)1. or subparagraph (a)2. for each person having at least a 10-percent interest in the firm, partnership, association, or corporation* and, if applicable, of the administrator, including the name and address of any long-term care facility with which the applicant or administrator has been affiliated through ownership or employment within 5 years of the date of the application for a license; *and a signed affidavit disclosing any financial or ownership interest that the applicant, or any principal, partner, or shareholder thereof, holds or has held within the last 5 years in any other facility licensed under this part, or in any other entity that is licensed by the state or another state to provide health or residential care which closed or ceased to operate as a result of financial problems.*

Senator Weinstock moved the following amendments which were adopted:

Amendment 2—On page 6, strike all of lines 1-5 and insert:

(5) The department may levy a fine in an amount no greater than $5,000 upon each person or business entity that owns any interest in a facility that terminates operation without providing notice to the department and the residents of the facility at least 30 days before operation ceases. This fine shall not be levied against any facility involuntarily closed at the initiation of the department. The

Amendment 3—In title, on page 1, line 20, after the semicolon (;) insert: prohibiting a fine against a facility closed by the Department of Health and Rehabilitative Services;

SB 2454

The Committee on Finance, Taxation and Claims recommended the following amendments which were moved by Senator Diaz-Balart and adopted:

Amendment 1—On page 4, lines 28 and 29, strike ", plus interest thereon from date of said judgment,"

Amendment 2—On page 5, strike all of lines 5-7 and insert: appropriated the sum of $250,000, payable to Damian Garcia, to compensate him

Amendment 3—On page 5, lines 11 and 12, strike "plus interest thereon as aforesaid"

AMENDMENTS TO HOUSE BILLS

HB 1221

Senator Langley moved the following amendments which were adopted:

Amendment 1—On page 2, strike all of lines 20-22 and insert: in Florida is required.

Amendment 2—In title, on page 1, strike all of lines 10 and 11 and insert: amending

ROLL CALLS ON SENATE BILLS

CS for SB 60

Yeas—30

Madam President	Crotty	Kiser	Souto
Bankhead	Dantzler	Kurth	Thomas
Beard	Diaz-Balart	Langley	Thurman
Brown	Dudley	Malchon	Walker
Bruner	Forman	McKay	Weinstein
Casas	Grant	Meek	Yancey
Childers	Grizzle	Myers	
Crenshaw	Johnson	Plummer	

Nays—1

Weinstock

CS for SB 296

Yeas—31

Madam President	Crotty	Kirkpatrick	Souto
Bankhead	Dantzler	Kiser	Thomas
Beard	Diaz-Balart	Kurth	Thurman
Brown	Dudley	Malchon	Walker
Bruner	Forman	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Yancey
Crenshaw	Johnson	Plummer	

Nays—1

Langley

Vote after roll call:

Yea—Girardeau

CS for CS for SB 498

Yeas—29

Madam President	Crotty	Kiser	Thomas
Bankhead	Dantzler	Kurth	Thurman
Beard	Diaz-Balart	Langley	Walker
Brown	Dudley	Malchon	Wexler
Bruner	Girardeau	McKay	Yancey
Casas	Grant	Meek	
Childers	Grizzle	Plummer	
Crenshaw	Johnson	Scott	

Nays—None

Vote after roll call:

Yea—Kirkpatrick, Souto

CS for SB 596

Yeas—30

Madam President	Crotty	Kiser	Souto
Bankhead	Dantzler	Kurth	Thomas
Beard	Diaz-Balart	Langley	Thurman
Brown	Dudley	Malchon	Walker
Bruner	Forman	McKay	Weinstein
Casas	Grant	Meek	Yancey
Childers	Grizzle	Myers	
Crenshaw	Johnson	Plummer	

Nays—None

Vote after roll call:

Yea—Girardeau, Kirkpatrick, Scott, Weinstock

CS for SB 632

Yeas—31

Madam President	Diaz-Balart	Johnson	Souto
Bankhead	Dudley	Kiser	Thomas
Beard	Forman	Kurth	Thurman
Brown	Gardner	Langley	Walker
Bruner	Girardeau	Malchon	Weinstock
Casas	Grant	McKay	Wexler
Childers	Grizzle	Meek	Yancey
Crenshaw	Jenne	Plummer	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

SB 738

Yeas—24

Brown	Diaz-Balart	Kurth	Thurman
Bruner	Dudley	Malchon	Walker
Casas	Forman	Meek	Weinstein
Childers	Gardner	Plummer	Weinstock
Crotty	Jenne	Souto	Wexler
Dantzler	Kiser	Thomas	Yancey

Nays—7

Bankhead	Grant	Johnson	Myers
Crenshaw	Grizzle	Langley	

Vote after roll call:

Yea—Girardeau

CS for SB 938

Yeas—32

Madam President	Crotty	Grizzle	Plummer
Bankhead	Dantzler	Johnson	Scott
Beard	Diaz-Balart	Kiser	Souto
Brown	Dudley	Kurth	Thurman
Bruner	Forman	Langley	Walker
Casas	Gardner	Malchon	Weinstock
Childers	Girardeau	McKay	Wexler
Crenshaw	Grant	Meek	Yancey

Nays—None

Vote after roll call:

Yea—Kirkpatrick, Thomas

CS for SB 1026

Yeas—22

Bankhead	Dantzler	Kirkpatrick	Scott
Beard	Dudley	Kiser	Thurman
Brown	Gardner	Langley	Walker
Bruner	Girardeau	Malchon	Yancey
Childers	Grant	Meek	
Crenshaw	Johnson	Myers	

Nays—10

Crotty	Grizzle	Souto	Wexler
Diaz-Balart	Jenne	Weinstein	
Forman	Kurth	Weinstock	

CS for SB 1116

Yeas—33

Madam President	Dantzler	Kiser	Thomas
Bankhead	Diaz-Balart	Kurth	Thurman
Beard	Dudley	Langley	Walker
Brown	Forman	Malchon	Weinstock
Bruner	Gardner	McKay	Wexler
Casas	Grant	Meek	Yancey
Childers	Grizzle	Plummer	
Crenshaw	Jenne	Scott	
Crotty	Johnson	Souto	

Nays—None

Vote after roll call:

Yea—Girardeau, Kirkpatrick

SB 1168

Yeas—26

Madam President	Crotty	Johnson	Scott
Beard	Dantzler	Kirkpatrick	Thurman
Brown	Diaz-Balart	Kiser	Weinstein
Bruner	Dudley	Langley	Wexler
Casas	Forman	Malchon	Yancey
Childers	Grant	Meek	
Crenshaw	Jenne	Myers	

Nays—None

Vote after roll call:

Yea—Souto

CS for CS for SB 1264

Yeas—31

Madam President	Diaz-Balart	Kiser	Souto
Beard	Dudley	Kurth	Thomas
Brown	Forman	Langley	Thurman
Bruner	Girardeau	Malchon	Walker
Casas	Grant	Meek	Weinstein
Crenshaw	Grizzle	Myers	Weinstock
Crotty	Johnson	Plummer	Yancey
Dantzler	Kirkpatrick	Scott	

Nays—None

CS for SB 1282

Yeas—30

Madam President	Dantzler	Langley	Thurman
Beard	Diaz-Balart	Malchon	Walker
Brown	Dudley	McKay	Weinstein
Bruner	Forman	Meek	Weinstock
Casas	Grizzle	Myers	Wexler
Childers	Jenne	Scott	Yancey
Crenshaw	Johnson	Souto	
Crotty	Kiser	Thomas	

Nays—None

Vote after roll call:

Yea—Grant, Kirkpatrick

CS for SB 1342

Yeas—31

Madam President	Crotty	Johnson	Thomas
Bankhead	Dantzler	Kirkpatrick	Thurman
Beard	Diaz-Balart	Malchon	Walker
Brown	Dudley	McKay	Weinstein
Bruner	Forman	Meek	Weinstock
Casas	Grant	Myers	Wexler
Childers	Grizzle	Plummer	Yancey
Crenshaw	Jenne	Souto	

Nays—1

Langley

Vote after roll call:

Yea—Girardeau

CS for SB 1440

Yeas—32

Madam President	Diaz-Balart	Kiser	Scott
Bankhead	Dudley	Kurth	Souto
Beard	Forman	Langley	Thomas
Brown	Girardeau	Malchon	Thurman
Casas	Grant	McKay	Walker
Childers	Grizzle	Meek	Weinstein
Crenshaw	Johnson	Myers	Weinstock
Crotty	Kirkpatrick	Plummer	Yancey

Nays—1

Bruner

CS for SB 1536

Yeas—31

Madam President	Crotty	Kirkpatrick	Plummer
Bankhead	Dantzler	Kiser	Scott
Beard	Diaz-Balart	Kurth	Thurman
Brown	Dudley	Langley	Walker
Bruner	Forman	Malchon	Weinstein
Casas	Grant	McKay	Weinstock
Childers	Grizzle	Meek	Yancey
Crenshaw	Johnson	Myers	

Nays—None

Vote after roll call:

Yea—Girardeau, Thomas

CS for SB 1548

Yeas—31

Madam President	Bruner	Crotty	Forman
Bankhead	Casas	Dantzler	Grant
Beard	Childers	Diaz-Balart	Grizzle
Brown	Crenshaw	Dudley	Jenne
Johnson	McKay	Thomas	Weinstock
Kirkpatrick	Meek	Thurman	Wexler
Langley	Myers	Walker	Yancey
Malchon	Souto	Weinstein	

Nays—None

Vote after roll call:

Yea—Girardeau

SB 1654

Yeas—27

Madam President	Diaz-Balart	Kiser	Thomas
Bankhead	Dudley	McKay	Thurman
Beard	Forman	Meek	Walker
Bruner	Girardeau	Myers	Weinstein
Casas	Grant	Plummer	Weinstock
Childers	Grizzle	Scott	Yancey
Crenshaw	Johnson	Souto	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

CS for CS for SB 1680

Yeas—30

Madam President	Crotty	Johnson	Thomas
Bankhead	Dantzler	Kurth	Thurman
Beard	Diaz-Balart	Langley	Walker
Brown	Dudley	Malchon	Weinstock
Bruner	Forman	McKay	Wexler
Casas	Girardeau	Meek	Yancey
Childers	Grant	Plummer	
Crenshaw	Grizzle	Scott	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

SB 1682

Yeas—31

Madam President	Dantzler	Kirkpatrick	Thomas
Bankhead	Diaz-Balart	Langley	Thurman
Beard	Dudley	Malchon	Walker
Brown	Forman	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Wexler
Crenshaw	Jenne	Plummer	Yancey
Crotty	Johnson	Souto	

Nays—None

Vote after roll call:

Yea—Bruner, Girardeau

SB 1838

Yeas—31

Madam President	Diaz-Balart	Kurth	Souto
Bankhead	Dudley	Langley	Thomas
Beard	Forman	Malchon	Thurman
Bruner	Girardeau	McKay	Walker
Casas	Grant	Meek	Weinstein
Childers	Grizzle	Myers	Weinstock
Crenshaw	Johnson	Plummer	Yancey
Crotty	Kiser	Scott	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

SB 2388

Yeas—29

Madam President	Dantzler	Johnson	Walker
Bankhead	Diaz-Balart	Kiser	Weinstein
Beard	Dudley	Kurth	Weinstock
Brown	Forman	Langley	Wexler
Casas	Girardeau	Malchon	Yancey
Childers	Grant	Myers	
Crenshaw	Grizzle	Souto	
Crotty	Jenne	Thomas	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

SB 2454

Yeas—28

Madam President	Crenshaw	Grizzle	Plummer
Bankhead	Crotty	Johnson	Souto
Beard	Dantzler	Kiser	Thurman
Brown	Diaz-Balart	Kurth	Weinstein
Bruner	Dudley	Malchon	Weinstock
Casas	Forman	Meek	Wexler
Childers	Grant	Myers	Yancey

Nays—None

Vote after roll call:

Yea—Kirkpatrick

ROLL CALLS ON HOUSE BILLS

HB 189

Yeas—30

Madam President	Diaz-Balart	Kurth	Thurman
Brown	Dudley	Malchon	Walker
Bruner	Forman	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Wexler
Crenshaw	Jenne	Plummer	Yancey
Crotty	Johnson	Scott	
Dantzler	Kiser	Souto	

Nays—None

Vote after roll call:

Yea—Bankhead, Kirkpatrick

CS for HB 269

Yeas—29

Madam President	Dantzler	Kurth	Walker
Bankhead	Diaz-Balart	Malchon	Weinstein
Beard	Dudley	Meek	Weinstock
Brown	Forman	Myers	Wexler
Bruner	Grant	Plummer	Yancey
Childers	Grizzle	Scott	
Crenshaw	Jenne	Souto	
Crotty	Johnson	Thurman	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

ABSTENTION FROM VOTING

I did not vote on **CS for HB 269**, a claims bill. I have been associated with the plaintiff's law firm on cases in the past and this may be a conflict of interest.

Richard H. Langley, 11th District

HB 287

Yeas—31

Madam President	Crotty	Kirkpatrick	Scott
Bankhead	Dantzler	Kiser	Souto
Beard	Diaz-Balart	Kurth	Thurman
Brown	Dudley	Langley	Weinstein
Bruner	Forman	Malchon	Weinstock
Casas	Grant	McKay	Wexler
Childers	Grizzle	Meek	Yancey
Crenshaw	Johnson	Myers	

Nays—None

CS for HB 339

Yeas—32

Madam President	Crotty	Johnson	Scott
Bankhead	Dantzler	Kiser	Souto
Beard	Diaz-Balart	Kurth	Thurman
Brown	Dudley	Malchon	Walker
Bruner	Forman	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Wexler
Crenshaw	Jenne	Plummer	Yancey

Nays—1

Langley

Vote after roll call:

Yea—Kirkpatrick

CS for HB 367

Yeas—18

Madam President	Crenshaw	Kiser	Walker
Bankhead	Diaz-Balart	Malchon	Weinstein
Beard	Forman	Meek	Yancey
Brown	Grant	Myers	
Childers	Grizzle	Plummer	

Nays—11

Bruner	Dudley	Kurth	Weinstock
Crotty	Jenne	Langley	Wexler
Dantzler	Johnson	Scott	

Vote after roll call:

Yea—Kirkpatrick

HB 369

Yeas—31

Madam President	Dantzler	Kiser	Thomas
Bankhead	Diaz-Balart	Kurth	Thurman
Beard	Dudley	Langley	Walker
Brown	Forman	Malchon	Weinstein
Bruner	Grant	Meek	Weinstock
Casas	Grizzle	Myers	Wexler
Childers	Jenne	Plummer	Yancey
Crotty	Johnson	Souto	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

HB 885

Yeas—30

Madam President	Dantzler	Kirkpatrick	Thurman
Beard	Diaz-Balart	Kurth	Walker
Brown	Dudley	Malchon	Weinstein
Bruner	Forman	McKay	Weinstock
Casas	Grant	Meek	Wexler
Childers	Grizzle	Myers	Yancey
Crenshaw	Jenne	Scott	
Crotty	Johnson	Souto	

Nays—None

CS for HB 979

Yeas—30

Madam President	Dantzler	Kiser	Thomas
Bankhead	Diaz-Balart	Langley	Walker
Beard	Dudley	Malchon	Weinstein
Brown	Forman	McKay	Weinstock
Casas	Grant	Meek	Wexler
Childers	Grizzle	Myers	Yancey
Crenshaw	Jenne	Plummer	
Crotty	Johnson	Souto	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

CS for HB 981

Yeas—32

Madam President	Crotty	Kiser	Souto
Bankhead	Diaz-Balart	Kurth	Thomas
Beard	Dudley	Langley	Thurman
Brown	Forman	Malchon	Walker
Bruner	Grant	Meek	Weinstein
Casas	Grizzle	Myers	Weinstock
Childers	Jenne	Plummer	Wexler
Crenshaw	Johnson	Scott	Yancey

Nays—1

Dantzler

Vote after roll call:

Yea—Kirkpatrick

CS for HB 983

Yeas—33

Bankhead	Dudley	Langley	Thurman
Beard	Forman	Malchon	Walker
Bruner	Girardeau	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Wexler
Crenshaw	Jenne	Plummer	Yancey
Crotty	Johnson	Scott	
Dantzler	Kiser	Souto	
Diaz-Balart	Kurth	Thomas	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

HB 1221

Yeas—30

Madam President	Crotty	Grizzle	Plummer
Bankhead	Dantzler	Johnson	Scott
Beard	Diaz-Balart	Kiser	Souto
Brown	Dudley	Kurth	Thurman
Bruner	Forman	Langley	Walker
Casas	Gardner	Malchon	Yancey
Childers	Girardeau	McKay	
Crenshaw	Grant	Meek	

Nays—None

Vote after roll call:

Yea—Kirkpatrick, Thomas

HB 1419

Yeas—32

Madam President	Crotty	Johnson	Scott
Bankhead	Dantzler	Kiser	Souto
Beard	Diaz-Balart	Kurth	Thurman
Brown	Dudley	Malchon	Walker
Bruner	Forman	McKay	Weinstein
Casas	Grant	Meek	Weinstock
Childers	Grizzle	Myers	Wexler
Crenshaw	Jenne	Plummer	Yancey

Nays—1

Langley

Vote after roll call:

Yea—Kirkpatrick

HB 1963

Yeas—29

Madam President	Crotty	Johnson	Walker
Bankhead	Dantzler	Kurth	Weinstein
Beard	Diaz-Balart	McKay	Weinstock
Brown	Dudley	Meek	Wexler
Bruner	Forman	Myers	Yancey
Casas	Grant	Plummer	
Childers	Grizzle	Scott	
Crenshaw	Jenne	Souto	

Nays—None

Vote after roll call:

Yea—Kirkpatrick

ENROLLING REPORTS

Senate Bills 578 and 1092 have been enrolled, signed by the required Constitutional Officers and presented to the Governor on April 19, 1991.

Joe Brown, Secretary

CORRECTION AND APPROVAL OF JOURNAL

The Journal of April 18 was corrected and approved.

RECESS

Senator Thomas moved that the Senate stand in recess for the purpose of holding committee meetings and conducting other Senate business until Monday, April 22, at 2:00 p.m. The motion was adopted.

Pursuant to the motion by Senator Thomas, the Senate recessed at 3:07 p.m. to reconvene at 2:00 p.m., Monday, April 22.